Vaya Health

Provider Operations Manual

SECOND EDITION
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VAYAHEALTH

Helpful Contacts

DEPARTMENT OR TEAM	POINT OF CONTACT
✓ **Provider Help Line** • General Questions/ Technical Assistance • Requests to add a site or service	**1-866-990-9712** ProviderInfo@VayaHealth.com
✓ **Compliance Hotline (24/7/365)** • Report Fraud, Waste or Abuse • Report Suspicious Billing	**1-866-916-4255** LegalandCompliance@VayaHealth.com
✓ **Claims** • Billing and Reimbursement • RAs, Credit Memos, Service Codes	**1-800-893-6246, Ext. 2455** Claims@VayaHealth.com
✓ **Eligibility and Enrollment** • Health plan eligibility & enrollment • Client updates	**1-800-893-6246, Ext. 2355** EandE@VayaHealth.com
✓ **Credentialing Hotline** • Credentialing and re-credentialing • Update/ change information • Add new practitioners to agency roster	**1-855-432-9139** CredentialingTeam@VayaHealth.com
✓ **Care Management** • Authorizations and Service Definitions • Clinical Practice Guidelines	**1-800-893-6246, Ext. 1513** UM@VayaHealth.com
✓ **Member Appeals** • Peer-to-Peer Discussions • Reconsideration of Authorization Decisions	**1-800-893-6246, Ext. 1400**
✓ **Help Desk/Mgmt Info Services (MIS)** • Alpha system issues • Electronic billing (837/835)	**1-800-893-6246, Ext. 1500** Helpdesk@VayaHealth.com
✓ **Access to Care Line (24/7/365)** • Help for appointments and referrals • Link to Mobile Crisis Management	**1-800-849-6127**
✓ **Customer Services Line** • Report a compliment, complaint or concern	**1-888-757-5726** Grievances@VayaHealth.com

Welcome to Vaya

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

At Vaya, we take partnerships with providers very seriously. You enable us to move toward our organization's vision of creating "communities where people get the help they need to live the life they choose."

Working together, Vaya and our contracted providers, alongside our Provider Advisory Council, are developing a strong network of community-based and specialty services and supports for some of our region's most vulnerable residents. Providers such as you enable residents of western North Carolina to access quality services and supports in or near their home communities, including in many of our more rural counties.

We remain committed to meeting your needs, standardizing business functions and strengthening our relationships with contracted providers. These partnerships are critical as we evolve in a rapidly changing healthcare landscape with an increased focus on whole-person, integrated care.

Vaya's core values embrace person-centeredness, integration, commitment and integrity. Likewise, these values guide our approach in developing our provider network and the approach that Network Providers take in delivering services to those in need.

We commend you, and our provider network overall, for your dedication to the people we mutually serve. Together, we are making a positive impact on western North Carolina not only today, but also for generations to come.

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

Brian Ingraham
CEO, Vaya Health

Mission, Vision and Values

Mission Statement ("Who We Are")

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

Vision Statement ("What We're Building")

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

Values ("What We Believe In")

- Person-Centeredness: Interacting with compassion, cultural sensitivity, honesty and empathy.
- Integration: Caring for the Whole Person within the home and community of an individual's choice.
- Commitment: Partnering with members, families, providers and others to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better.
- Integrity: Ensuring quality care and accountable financial stewardship through ethical, responsive, transparent and consistent leadership and business operations.

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Section 1: About Vaya

Congratulations on joining the Vaya Provider Network! Vaya developed this Provider Operations Manual to provide detailed information and technical assistance to Vaya Network Providers on all requirements of network participation. A Network Provider is an appropriately credentialed provider of mental health, intellectual and/or developmental disabilities, or substance use disorder (MH/IDD/SUD) services, and who has a contract in effect for participation in the Vaya Closed Provider Network as set forth at 42 CFR § 438.2. Network participation means that you are listed in the Vaya Network Directory and are eligible for referrals from Vaya. This does not include providers who are serving a member under an Out of Network Agreement. Participation is based on selection and retention criteria outlined in Section 2 of this Manual.

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

All references to timeframes in this Manual refer to calendar days unless otherwise stated. A "business" or "working" day means Monday through Friday, 8:30 a.m. through 5:00 p.m. with the exception of any day recognized by Vaya as an official holiday, as well as any day Vaya is not open for administrative functions due to a weather-related event or other natural cause. To provide suggestions or feedback about the information in this Manual, please call Vaya's Provider Network Department at 1-866-990-9712 or email us at Manuals@VayaHealth.com. We look forward to hearing from you.

What is Vaya Health?

Vaya is a local political subdivision of the State of North Carolina and a Local Management Entity/ Managed Care Organization (LME/MCO) as that term is defined at N.C.G.S. § 122C-3(20c). We operated under the name Smoky Mountain Center for Mental Health, Developmental Disabilities and Substance Abuse Services since 1972, and changed our name to Vaya Health in September 2016. We operate a Medicaid Prepaid Inpatient Health Plan on a capitated per member per month (PMPM) basis pursuant to a contract with the NC Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) and in accordance with the NC 1915(b)/(c) combined Medicaid Waiver (the "Waiver"). North Carolina's combined Medicaid Waiver includes a 1915(b) Service Delivery Waiver known as the "MH/DD/SA Health Plan," and a 1915(c) Home and Community Based Services Waiver for persons with intellectual and/or developmental disabilities (I/DD) who meet institutional level of care criteria referred to as the "Innovations Waiver".

Vaya also receives state and federal Block Grant funding pursuant to a contract with the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). Under our contracts

with DMA and DMH/DD/SAS, we are responsible for the planning, development, implementation, management, and monitoring/ oversight of all publicly-funded MH/IDD/SUD services in a 23-county catchment area comprised of Alleghany, Alexander, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes and Yancey counties. This includes payment and reimbursement for services within available funding.

Essentially, Vaya operates three different health benefit plans: (1) the MH/DD/SA Health Plan for Medicaid beneficiaries whose eligibility is based in Vaya's catchment area and need MH/IDD/SUD services; (2) the Innovations Waiver Health Plan for Innovations Waiver participants whose eligibility is based in Vaya's catchment area; and (3) a Non-Medicaid Benefit Plan for persons who need MH/IDD/SUD services and meet financial and other eligibility criteria. The Non-Medicaid Benefit Plan includes federal Block Grant funding, state MH/DD/SA funding, and funding from counties in our catchment area. Each benefit plan contains its own distinct set of services and eligibility criteria.

Vaya is accredited by URAC in the areas of Health Call Center, Health Network, and Health Utilization Management. We are responsible for operating a 24/7/365 Call Center that provides screening, triage, and referral services as well as crisis intervention. We protect public funding through utilization management and utilization review that ensure requested services are medically necessary, as well as claims adjudication and data mining that guard against fraud, waste and abuse. We ensure accessibility, availability and quality of MH/IDD/SUD services through our network development, credentialing, quality management, and monitoring and investigation efforts. We also offer care coordination services to eligible members. Your roles and responsibilities related to each of these functions is described in this Manual.

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

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

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

About the 1915 (b) MH/DD/SA Health Plan Waiver

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

requirements of the Social Security Act are waived:

- Waives state-wideness: Allows North Carolina to implement behavioral health managed care plans in specific areas of the state, such as Vaya's 23-county region
- Waives comparability of services: Lets North Carolina provide different benefits to people enrolled in the managed care system
- Waives freedom of choice: Allows Vaya to operate a closed network of providers and require members to choose from providers within that network, with some limited exceptions

About the N.C. Innovations 1915 (c) Waiver

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

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

Where is Vaya located?

Vaya's administrative headquarters are centrally located in Buncombe County, with additional regional office locations accessible to providers, community stakeholders and members throughout our 23 counties, including co-locations with county Health Departments, Departments of Social Services and Network Providers. We also support a number of home-based employees to ensure a local presence in our communities. Addresses and phone numbers for our regional offices are listed on the following page. Please note that you do not need to dial the local number – all Vaya offices and staff can be reached toll-free by calling **1-800-893-6246**.

Buncombe County (Administrative Offices) 200 Ridgefield Court, Suite 206, Asheville, NC 28806 Telephone: 828-225-2785 Facsimile: 828-252-9584	**Jackson County** 44 Bonnie Lane, Sylva, NC 28779 Telephone: 828-586-5501 Facsimile: 828-586-3965
Caldwell County 825 Wilkesboro Blvd. SE, Lenoir, NC 28645 Telephone: 828-759-2160 Facsimile: 828-759-2161	**Watauga County** 895 State Farm Road, Suite 507, Boone, NC 28607 Telephone: 828-265-5315 Facsimile: 828-262-1859

Governance and Administration

Vaya is governed by a 21-member Board of Directors appointed under N.C.G.S. Chapter 122C. Our Board includes 6 individuals with specifically denominated expertise consistent with the nature of managed care operations, a County Commissioner representative, a member appointed by the DHHS Secretary, a hospital administrator, 3 members of our Consumer and Family Advisory Committee (CFAC), 8 at-large members, and the President of the Vaya Provider Advisory Council, who serves in a non-voting *ex officio* capacity. The Board provides broad oversight and policy direction for the organization and ensures that Vaya is accountable to community needs and local government. The Board actively and regularly reviews reports on finances, regulatory compliance, performance, quality, service utilization, customer service, unmet local service needs, access to services and provider capacity

Vaya's administrative structure includes the Chief Executive Officer (CEO), Executive Leadership Team (ELT), numerous committees and cross functional teams (CFTs), and internal departments responsible for broad functional areas including: Executive Administration, Care Coordination, Community Relations, Customer Services, Finance, Human Resources, Legal & Compliance, Management Information Services, Marketing & Communications, Performance & Quality Improvement, Provider Network Operations and Utilization Management.

Information about Vaya Departments

Office of the CEO and Executive Administration: The CEO is responsible for overall management of the LME/MCO, including day-to-day leadership, oversight and administration, allocation of funding and resources and strategic planning. The CEO works directly with DHHS and other government and elected officials, provider executives and community leaders to negotiate strategic partnerships, develop innovative health care planning initiatives and respond to national and state healthcare policy changes. In addition to the CEO, Vaya's Executive Leadership Team includes the Chief Operations Officer, General Counsel/ Chief Compliance Officer, Chief Medical Officer, Chief Information Officer, Chief Population Health Officer and the Chief Financial Officer, all of whom report directly to the CEO.

Care Coordination (CC): Care coordination is a service offered by Vaya to eligible Medicaid enrollees, including

those who meet special needs population criteria in accordance with 42 CFR § 438.208, or to individuals eligible for state funds who are high risk/ high cost or at a critical treatment juncture as set forth at N.C.G.S. § 122C-115.4(5). This includes Innovations Waiver participants, persons with complex MH/SA needs or who are at high risk for institutional or residential placement, as well as individuals who are discharged from inpatient or residential facilities who are not linked to a Clinical Home, under outpatient commitment, not receiving appropriate services and/or need assistance returning to the community. An Acute Care Response Team includes in-house hospital liaisons who work with community hospitals and state-operated facilities to ensure effective discharge planning, as well as other acute response care coordinators who work to reduce or divert inappropriate emergency department (ED) utilization, and help providers, members, families and stakeholders with members experiencing an acute crisis or emergent care need. Care Coordination also includes the Geriatric and Mental Health Specialty Team (GAMHST), which provides education and consultation for staff of long-term care facilities, as well as family members and caregivers of individuals 60 years and older with mental illness or other emotional or behavioral challenges, or who are experiencing early onset of dementia or other geriatric-type health illnesses. For more information about care coordination, see Section 9 of this Manual.

Community Relations: The Community Relations department includes two dedicated County Relations Representatives to ensure timely and effective response to the needs of our constituent counties. It also includes Vaya's member relations team, which is responsible for providing support to the Human Rights Committee and the Vaya CFAC. This team also includes Peer Trainers and Family Partners who assist members and families in navigating the system, develop and maintain member and family support networks, support families to lead the person and family centered planning process, provide Wellness Recovery Action Plan (WRAP) and Certified Peer Support specialist trainings, provide individualized peer support for members with identified unmet needs, and operate a toll-free number that gives members the opportunity to speak with someone at Vaya who has lived experience related to MH/IDD/SUD issues.

Customer Services: Customer Services is responsible for URAC-accredited Health Call Center functions and operates a 24/7/ toll-free Access to Care Line 365 days a year for individuals who are in crisis or seeking access to services. The Call Center also operates an 8:00 am – 5 pm (Monday – Friday) Customer Services Line for general inquiries and assistance. Customer Service Clinicians perform screening and triage using uniform clinical decision support tools that measure acuity, and make referrals to Network Providers in accordance with urgent, emergent and routine access and appointment standards established by DHHS, including referrals to mobile crisis management providers in order to appropriately divert from the ED. Customer Services Representatives (CSRs) perform initial screening and member satisfaction surveys, warm transfer calls to licensed clinicians when needed, answer general questions, provide information about MH/IDD/SUD resources and services and the Vaya Health Plan(s), take down complaints and grievances and follow up on appointments and provider availability. The Grievance Team tracks, responds to, and refers for investigation or resolves complaints, grievances and quality of care concerns filed by members, relatives, staff, providers and other stakeholders. For more information about Vaya's Call Center, see Section 4 of this Manual.

Finance: The Finance Department is responsible for all finance and accounting functions, including but not limited to enrollment and eligibility, claims processing and adjudication in compliance with DMA prompt pay requirements, and provider and vendor reimbursement. Finance is also responsible for development of the

annual budget and the annual service management plan in conjunction with PN, which allocates the federal Block Grant, and state and county funds received by Vaya.

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

Legal & Compliance: Vaya's team of legal and compliance professionals is responsible for procurement and contracting, litigation, risk management, records management, provider dispute resolution, regulatory compliance, government relations, support to the Board of Directors, review and approval of Vaya policies, procedures, manuals, forms and templates, Waiver Contract management and oversight of Vaya's Regulatory Compliance Committee and Privacy Officer functions. The Waiver Contract Manager is the chief liaison with DMA and is responsible for monitoring Vaya's adherence to the 1915(b)/(c) Waiver and the DMA Contract, including reporting requirements. The General Counsel and other in-house attorneys provide daily advice and counsel to Vaya leadership and staff on a wide array of legal, compliance and risk issues confronting the organization. **However, they do not represent, and cannot provide legal advice to, Vaya Network Providers.**

Management Information Services (MIS): Under the direction of the CIO, the MIS Department is responsible for all aspects of research, development, operations, and support for Vaya's network infrastructure, telecommunications, and computer systems, including the electronic authorization and claims processing system (AlphaMCS), which supports secure transmission of data via standard Electronic Data Interchange (EDI) formats. MIS also develops Vaya's contingency plan for backup, disaster recovery and emergency operations and securely protects all sensitive electronic information, including Protected Health Information (PHI) maintained by Vaya. The CIO also oversees Information Security, Facilities, and the Project Management Office (PMO), which is responsible for oversight and management of Vaya's projects and initiatives to ensure appropriate prioritization and alignment with strategic goals. For questions related to AlphaMCS, please call 828-225-2785 Ext. 1500 or email Helpdesk@VayaHealth.com.

Marketing & Communications: Under the direction of the General Counsel, this department is responsible for internal and external communications including provider communication bulletins, as well as press releases, marketing, website development and content management, health literacy, public event planning and coordination with broadcast, print, web-based and social media.

Performance & Quality Improvement (PQI): PQI includes 4 teams (Contract Performance, Incident Response, Quality Improvement, and Special Investigations) that are responsible for ensuring quality services and compliance with regulations and contractual agreements of all providers serving Vaya members, including: complaint investigations; responding to allegations of fraud, waste and abuse; referral of suspected fraud to DMA and the Medicaid Investigations Division of the NC Department of Justice for potential civil and/or criminal investigation; focused monitoring; health and safety investigations; tracking, gathering follow-up information, and coordinating the review of incidents filed by providers in the State's Incident Response Improvement System (IRIS), post payment review, routine monitoring, and site reviews. PQI also collaborates with providers

by providing technical assistance and solutions for correcting out of compliance findings. Within PQI, the Quality Improvement Team oversees the Vaya Quality Management Program, which includes: (a) quality improvement; (b) oversight of the collection, integration, analysis, and reporting of data necessary for the evaluation of system performance; (c) the application of quality management principles and techniques as a means of achieving organizational goals that further the mission of Vaya; (d) compliance with all DHHS performance reporting requirements; and (e) review of performance indicators and commissioning of organizational resources to address identified areas for remediation or improvement. Reports and the results of quality improvement projects are presented to DHHS, CFAC and the Board Regulatory Compliance & Quality Committee, and are used for planning, decision making, and system improvement. For more information about Quality Management, see Section 15 of this Manual. For more information about audits, monitoring and investigations, see Section 16 of this Manual.

Provider Network Operations (PN): PN is responsible for URAC-accredited Health Network functions, including network development, credentialing, and network management. The PN Department includes 4 teams: Credentialing, Housing & Employment, Network Development and Provider Relations. PN recruits, selects, and credentials all participating providers to ensure quality services, fiscal sustainability, geographic accessibility and member choice, where required. The Credentialing Team is responsible for credentialing and re-credentialing of applicants and Network Providers on behalf of Vaya and conducts Primary Source Verification of reported credentials to ensure quality. The Housing & Employment Team is responsible for assisting providers and members with key social determinants of health to minimize member crises. Network Development designs innovative programs to create and enhance access to care and improve service availability and efficiency, including capitated and outcome-based payment models, ensures that the Vaya Provider Search Tool and Provider Directory are accurate and up-to-date, assists other departments in identifying available providers to meet member needs, and is chiefly responsible for the development and submission of Vaya's annual required Provider Capacity, Community Needs Assessment, and Gaps Analysis. Provider Relations helps negotiate provider contracts and offers technical assistance to participating providers through a dedicated toll-free number and email account. For more information about Credentialing, see Section 3 of this Manual.

Transitions to Community Living Initiative (TCLI): This Department is responsible for activities associated with North Carolina's 2012 settlement with the U.S. Department of Justice related to diverting and transitioning members with serious and persistent mental illness from adult care homes and other institutions into the home and community of their choice with evidence-based, wrap-around services and supports that helps ensure long-term member stability. The TCLI implementation and oversight team is equally balanced with mental health professionals and NC Certified Peer Support Specialists, while additional support to participants comes from the cooperative efforts of Vaya's Care Coordination Department, Housing Specialists, and Employment Specialists.

Utilization Management (UM): UM is responsible for URAC-accredited Health Utilization Management functions, including prospective, concurrent and retrospective utilization review. UM evaluates the medical necessity, appropriateness and efficacy of requests for services against State Plan and Waiver requirements, benefit plan limitations and criteria, DMA Clinical Coverage Policies, DMH/DD/SAS Service Definitions, and established Clinical Practice Guidelines. The Clinical Support Team provides written notification of UM decisions and oversees the member reconsideration review process, which includes an impartial review by a clinical peer who

was not involved in the original decision. Under the direction of Vaya's Chief Medical Officer, UM also provides clinical support to other Vaya departments, and conducts service utilization and trend analysis to guide organizational decision-making. For more information about the authorization process, see Section 6 of this Manual.

Advisory Boards

Vaya has a number of advisory boards and subcommittees that provide input and recommendations to the governing board and executive leadership, including a Provider Advisory Council (PAC) discussed on the next page.

County Commissioner Advisory Board (CCAB): The CCAB serves as the chief advisory board to Vaya and the CEO on matters pertaining to the delivery of MH/IDD/SUD services within the catchment area and provides input on appointments to the Vaya Board of Directors. In accordance with N.C.G.S. § 122C-118.2, the CCAB consists of one county commissioner from each of the 23 Vaya counties. Members are designated by the board of commissioners of each county. The individual who serves as the County Commissioner Board member in accordance with N.C.G.S. § 122C-118.1(b)(1) serves as Chair of the CCAB. The CCAB serves in an advisory capacity only, and its duties do not include authority over Vaya budgeting, personnel matters, governance, or policymaking.

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

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

Vaya's CFAC meets at least 6 times per year and fulfills the composition requirements of N.C.G.S. § 122C-170, with 56 members representing all 23 counties in Vaya's service area, as well as all three disability groups. CFAC also has 4 regional sub-groups, which facilitates local planning for members and families as well as cross regional planning and implementation. The Board and CFAC work cooperatively in accordance with a mutually established Relational Agreement that addresses their roles and responsibilities and a method for conflict resolution. The Vaya CFAC liaison(s) provide staff support and coordination of information between Vaya, CFAC and the Board. CFAC members serve on a number of Vaya committees, including Quality Improvement, and three CFAC members serve as governing Board members.

For more information about CFAC, please contact us via email at CFAC@VayaHealth.com or refer to the CFAC page on our website: http://vayahealth.com/members-caregivers/cfac-member-outreach/cfac/.

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

Provider Advisory Council

As a Network Provider, you can participate in Vaya's Provider Advisory Council (PAC), which serves as an advisory body to Vaya on issues affecting Network Providers. The PAC is a self-governing committee that operates pursuant to a set of Bylaws, and includes three Regional Provider Collaboratives who nominate members for the full Council in a manner that ensures representation from a broad cross-section of provider types serving all three service areas. Members of the PAC serve as fair and impartial representatives of all Network Providers for the purpose of advocacy, support and communication.

The PAC is designed to facilitate an open exchange of ideas, shared values, goals, and visions and bring forward concerns and solutions while promoting collaboration, ethical operations, mutual accountability, and quality services. The objectives for the PAC include but are not limited to:

1. Foster partnerships with Vaya to address issues affecting the MH/IDD/SUD public service system.
2. Recommend and support the provision of best practices to empower members within Vaya's catchment area to achieve their personal goals.
3. Foster communication and collaboration between Network Providers in order to improve member care.
4. Provide input and recommendations to Vaya about clinical and provider payment policies, selection and retention criteria, dispute resolution mechanisms, the Provider Operations Manual, and other guidelines and requirements which directly impact Network Providers.
5. Assist in the dissemination of statewide Provider Satisfaction and Member Perception of Care surveys, provide input in the development of Vaya surveys, and make recommendations to improve survey participation and the perception of care in the community.
6. Review the results of surveys and the annual needs assessment and gap analysis, advise Vaya in the continued development of the Network Development Plan, and develop and make recommendations for service delivery models and gaps in services.
7. Address strategies regarding funding and financial issues, and provide feedback about network development initiatives, funding priorities and opportunities and Requests for Proposal (RFPs), Requests for Information (RFIs) and other procurement initiatives.

8. Assist in the development of global and individual provider performance outcomes, make recommendations for network quality management practices, and advise Vaya regarding service trends, quality improvement plans, utilization and performance measures, and provider quality and outcome indicators.
9. Provide feedback to Vaya about provider and community education, technical assistance and training needs.
10. Identify members to participate in designated Vaya committees and PAC subcommittees addressing initiatives such as quality improvement, credentialing, clinical practices, integrated care, training, bylaws, ethics, cultural competency, network development, provider manual, AlphaMCS, and finance/ claims.

For more information about the Provider Advisory Council or Regional PAC meetings, please refer to the PAC section of Vaya's website: http://vayahealth.com/providers/contract-providers/.

Code of Ethics

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

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

Stakeholder and Community Involvement

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

Vaya also maintains collaborative working relationships with a variety of community stakeholder and human service agencies within the catchment area to assess what services are working or needed and to ensure integration of care to support members who are involved with multiple agencies. These organizations include but are not limited to: county Departments of Social Services, local Health Departments, Federally Qualified Health Centers (FQHCs), community hospitals and regional health systems, public schools, law enforcement,

courts, Juvenile Court Counselors, NAMI, Community Care of North Carolina, Area Health Education Centers including MAHEC and NW AHEC, and primary care providers.

For more information about participating in a Vaya committee or providing feedback about Vaya's performance or policies, please contact the Provider Network Department at 1-866-990-9712 or via email at providerinfo@VayaHealth.com.

Provider Communications, Training and Technical Assistance

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

We require all Network Providers to remain up-to-date on relevant information and changes communicated by the DMA and DMH/DD/SAS through the following links on the DHHS website:

- Joint DMA and DMH/DD/SAS Communication Bulletins: https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins. These Bulletins superseded the previous joint DMA and DMH/DD/SAS Implementation Updates archived at http://www2.ncdhhs.gov/mhddsas/implementationupdates/index.htm, and the previous DMH/DD/SAS Communication Bulletins archived at https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins.
- Medicaid Bulletins available at https://dma.ncdhhs.gov/providers/medicaid-bulletins
- DMA Clinical Coverage Policies available at https://dma.ncdhhs.gov/providers/clinical-coverage-policies

Network Providers must keep abreast of changes in laws, rules, regulations or policies affecting the delivery of publicly-funded MH/IDD/SUD services, attend workshops and trainings to maintain clinical skills and/or licensure, be knowledgeable on evidence-based or emerging best practices, and be current on coding and reimbursement standards. Vaya provides a number of resources to assist you in meeting this requirement. We will communicate information regarding workshops in a variety of ways and will offer trainings or technical assistance as needed. You should regularly check our Events and Training Calendar for upcoming trainings: http://vayahealth.com/calendar/.

Vaya can provide technical assistance related to contract requirements, claims, billing and reimbursement, the requirements of this Manual, requirements of DHHS and other oversight authorities, the development of appropriate clinical services, authorization processes and quality improvement initiatives. We can also link you to national or state resources for technical assistance. However, we are not required to provide technical assistance in areas that would normally be considered standard operational activities in the healthcare industry

or to Network Providers that demonstrated they are unable to assimilate previous technical assistance provided by Vaya.

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

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

- Read all written communications sent to you by Vaya.
- Keep apprised of current information regarding service provision through communication bulletins offered by Vaya, other LME/MCOs if applicable, DHHS, DMA and DMH/DD/SAS.
- Review the Vaya, DHHS, DMA, and DMH/DD/SAS websites for updates on a regular basis.
- Ensure that your employees and contractors are informed of new and/or changing information as it relates to their function.
- Join national and state provider advocacy organizations to learn more about best practices.
- Attend Vaya's governing Board, CCAB, HRC or CFAC meetings.
- Attend and participate in PAC meetings, and other provider forums hosted by Vaya in order to learn from and about other Network Providers, and share suggestions and guidance on how to improve the MH/IDD/SUD system of care.
- Participate in provider trainings offered by Vaya, DHHS and other organizations.
- Invite Vaya staff to meet with you, your staff or your governing Board as needed to clarify issues or provide technical assistance.
- For more information, call the Provider Network Department at **1-866-990-9712** or contact us via email at providerinfo@VayaHealth.com. Our goal is to respond to all inquiries within 1 business day.

Section 2: Network Participation

Policy Statement

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

Background

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

Federal regulations require Vaya to maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Medicaid enrollees in the Vaya catchment area. When the Waiver was approved, CMS exempted North Carolina from complying with the provider "freedom of choice" requirements under the Social Security Act. This waiver is balanced by Vaya's responsibility to ensure accessibility of services. DHHS monitors the adequacy of our network through the annual Provider Capacity, Community Needs Assessment, and Gaps Analysis ("Gaps Analysis"), which is also used to inform our Network Development Plan.

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

There is no right under federal or state law for any provider to participate in our Closed Provider Network. The only exceptions are for emergency services or when there is no Network Provider available to provide medically necessary covered services to a particular individual. In fact, Section 7.6 of the DMA Waiver Contract explicitly

states that Vaya "shall have the authority to operate a Closed Network and shall not be required to review the qualifications and credentials of Providers that wish to become Network Members if the Network has sufficient numbers of Providers with the same or similar qualifications and credentials to provide adequate access to all services covered under this Contract in accordance with 42 CFR 438.206." The contract also states that we "have the sole discretion to determine provider participation in the PIHP Closed Network, including determinations regarding contract renewal and procurement, subject to the requirements of this Contract and Federal regulations."

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

Vaya department representatives meet at least annually to develop recommendations about renewals of existing contracts from a cross-functional perspective. Decisions about contract renewals are made in accordance with written selection and retention criteria as required by 42 CFR § 438.214. Our selection and retention criteria were initially vetted with the PAC in August 2014 and posted to our website for review and comment for 30 days in September 2014. The selection and retention criteria contained in this Manual are based on those initial criteria and have not substantially or significantly changed since that time. Please read them carefully.

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

Network Development Plan

The annual Gaps Analysis includes objective measures such as geo-mapping to help us analyze service access and availability throughout the catchment area, as well as input from member, family, provider and stakeholder surveys. Vaya maintains an ongoing Network Development Plan (NDP) that is informed by the Gaps Analysis and incorporated into our annual budget. At least annually, we review the NDP with the PAC. The NDP outlines our strategies for addressing the service and program development needs identified by Vaya staff and in the Gaps Analysis. Feedback from Vaya Departments, committees and Senior and Executive leadership are incorporated into the development of the plan. Progress is monitored through regular reports at the Executive and Board levels of the organization. Vaya's NDP will always reflect our commitment to flexible, accessible,

person-centered services which honor the dignity, respect the rights, and maximize the potential of the individual.

Non-Discrimination Statement

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

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

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

Good Standing

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

- The individual or entity and any owners, directors and managing employees are not excluded from participation in any federal health care program.
- The individual or entity and any owners, directors and managing employees have no relevant criminal history findings (see Section 3 of this Manual for more information about the types of offenses that are

flagged for review).

- The individual or entity and any owners, directors and managing employees did not previously own, operate or manage any provider entity that had its participation in any State's Medicaid program, the N.C. Health Choice program, the Medicare program, or another Medicaid managed care program involuntarily terminated for any reason.
- The individual or entity and any owners, directors and managing employees did not previously own, operate or manage any provider entity that owes an outstanding overpayment to U.S. DHHS, DHHS, Vaya or another LME/MCO.
- There are no current N.C. Health Choice, Medicare or Medicaid fines or sanction(s) in effect against the individual or entity by CMS or its contractors, or any State Medicaid agency, including but not limited to contract termination or suspension, referral suspension, payment suspension, moratorium, placement on prepayment review, or similar actions.
- The individual or entity has an acceptable professional liability history, defined as no history of liability claims for the last 5 years. An unacceptable liability history is defined as: within the 5 year period immediately preceding the date of application, one or more legal actions resulted in: (a) At least one judgment; (b) One settlement in an amount of $50,000 or more; or (c) Two or more settlements in an aggregate amount of $50,000 or more.
- The individual or entity does not owe any outstanding payments, fees, or documentation to any of the federal or state oversight authorities listed below, including but not limited to outstanding tax or payroll liabilities:
  - U.S. Department of Health and Human Services or any of its Divisions
  - NC Department of Health and Human Services or any of its Divisions
  - NC Secretary of State (if organized as a corporation, partnership or limited liability company)
  - U.S. Internal Revenue Service
  - NC Department of Revenue
  - NC Department of Labor
- No negative or questionable findings are identified for the individual or entity in any of the following databases/ oversight authorities:
  - U.S. HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
  - U.S. System for Award Management (SAM) consolidated excluded parties list
  - NC Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR)
  - NCTracks and/or National Plan & Provider Enumeration System (NPPES)
  - National Practitioner Data Bank (NPBD/HPDB)
  - National Technical Information Service for DEA certificates
  - Social Security Death Master File
  - DMA Program Integrity Database
  - National Accrediting Boards (e.g. CARF, Joint Commission on Accreditation of Hospitals)
  - Boards of Licensure or Certification for the applicable Scope of Practice
- The individual or entity is not currently subject to any of the following sanctions or administrative actions issued by Vaya, state or local regulatory agencies, or has not been subject to any such sanctions or administrative actions within the twelve (12) months prior to the application or renewal decision:

- Vaya or other LME/MCO: Contract Termination or Suspension, Suspension of Referrals, Unresolved Plan of Correction (POC), Outstanding Overpayment, Prepayment Review, Payment Suspension
- DMA: Contract Termination or Suspension, Payment Suspension Prepayment Review, Outstanding Final Overpayment
- DMH/DD/SAS: Revocation of Authority to Receive Public Funds, Unresolved POC
- DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active Summary Suspension, Active Notice of Revocation or Revocation in Effect
- N.C. Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, Revenue Suspension

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

Vaya considers an action of an LME/MCO to be final upon notification to the provider, unless the provider timely requested a reconsideration review, in which case Vaya considers the action final upon issuance of a decision by the applicable LME/MCO reconsideration panel. Vaya is not required to enroll an applicant in the Vaya Closed Network or renew a Network Contract if the individual or entity has an LME/MCO sanction pending at the Office of Administrative Hearings (OAH).

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

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

Cultural Competence

An important prerequisite to network participation is the development of a Cultural Competency Plan. Vaya requires all Network Providers to develop and implement a Cultural Competency Plan that is respectful and supportive of the cultural and diverse needs of members, families, stakeholders, communities and other agencies. Cultural competency is a guiding principle that must be incorporated into your mission and values and reflected in your decisions, policies, clinical protocols, and established benchmarks and outcome measures. We require all Network Providers to practice person-centered thinking in every aspect of service delivery in order to achieve cultural competence. You will be successful in achieving a culturally competent organization when the

skills and abilities needed for cultural competence become a priority at every level of the organization, including leadership and your Board of Directors (if applicable).

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

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

<u>Individually</u>

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

<u>Organizationally</u>

- Identify and adopt appropriate cultural diagnostic tools and train staff on their utilization.
- Advertise position openings in markets where minorities are exposed to the ads.
- Evaluate outreach and marketing strategies to ensure targeted communities and populations are reached.
- Practice inclusiveness.
- Acknowledge the interactive dynamics of cultural differences.
- Continuously expand cultural knowledge and resources with regard to populations served.
- Collaborate with the community regarding service provision and delivery
- Commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
- Earnestly participate in initiatives to achieve cultural competence.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner.
- Recognize and work to reduce potential barriers to treatment:
  - Stigma associated with receiving services

- Distrust of the system
- Perceived lack of confidentiality
- Services not located in the community where they are needed
- Lack of transportation
- Poverty
- Language
- Fear, of discrimination or otherwise
- Family or community shame
- Lack of Providers with a culturally appropriate or diverse staffing base

In the future, Vaya may require Network Providers to complete a Cultural Competence Self-Assessment Tool annually in order to evaluate your level of Cultural Competence. Areas to be assessed will likely include:

- Staff Composition
- Physical Environment
- Written Materials
- Website
- Phone System
- Policies and Procedures
- Training Program
- Communication of the Program

Identification of Service Needs

Vaya will not accept or review applications for new enrollment unless we identify a specific service need that cannot be address by our network of providers. **This includes applications from currently credentialed practitioners who are interested in leaving their contracted employer and starting an independent practice.** If a specific service need is identified and approved as the result of the Gaps Analysis or based on an internal review, Vaya may seek to add providers through a variety of means, including but not limited to direct provider contact, solicitation of applications via the weekly bulletin or website posting, or development of a procurement process for selection of an appropriate provider. Vaya is committed to ensuring the fiscal stability of its contracted Network Providers, and will only consider applications from new applicants for MH/IDD/SUD services if service capacity is not met, i.e. there is a demonstrated community or member service need. If Vaya identifies a specific need for a provider type, specialty or location, we will post a notification to our website. Providers seeking to enroll in the Vaya Closed Network for the first time, or Network Providers seeking to add a site or service to a Network Contract should check the Vaya website regularly for this information.

If we cannot identify existing Network Providers to meet an identified need, then we will seek to recruit new provider(s). If Vaya elects to pursue a formal procurement process, applicants must follow all steps identified in the applicable Request for Proposal (RFP) or Request for Information (RFI). Otherwise, the first step is for the applicant to complete and submit a Provider Nomination Form, available on our website. If the nomination is

approved, the provider will be sent an application for credentialing and enrollment that will include detailed instructions and timelines for completion.

Selection (Enrollment) Criteria

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

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

Network Provider Enrollment and Change Requests

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

approved, the Network Provider will be sent an application for credentialing and enrollment for the new site or service that will include detailed instructions and timelines for completion.

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

Existing Network Providers of Innovations Waiver services seeking to add an additional Innovations Waiver service to their Contract in order to serve a specific participant must be in good standing. The first step is to work with the assigned Care Coordinator to complete and submit the Provider Nomination Form. Requests will be reviewed and considered based, in part, on information from the Care Coordination department as to whether the additional Waiver service is necessary to meet a specific need. If the request is for a residential service that requires additional credentialing, it will be forwarded to the Credentialing Team to start the credentialing process. DMA guidelines require that all new applicants seeking to provide Innovations Waiver services must be nationally accredited in IDD service provision.

Retention (Renewal) Criteria

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

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

- The Network Provider is in breach of any provision of its current Contract with Vaya, including but not limited to a failure to comply with Controlling Authority and any applicable Scope of Work. Contract requirements reviewed may include but are not limited to:
    - Provision of services in accordance with all applicable state and federal laws, rules, regulations, the NC State Plan for Medical Assistance, the Waiver, State Service Definitions, and/or Clinical Coverage Policies;

- Meeting all medical necessity and documentation requirements as set forth in Medicaid Clinical Coverage Policies, State Service Definitions, and/or the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2;
- Cooperation and participation with all Vaya network integrity activities (including but not limited to audits, investigations and post-payment reviews), as well as Vaya process for utilization review/management, quality management, incident reporting, and member appeals and grievances.

- The Network Provider has not billed for services in the sixty (60) days prior to Vaya's review of the contract renewal, unless it concerns a provider of specialty or out-of-catchment area services that are delivered infrequently.
- The Network Provider is not in good standing as defined in this Manual.
- Vaya, DMA or CMS determines that the Network Provider falsified information provided on documentation submitted for re-credentialing, screening or enrollment in the Vaya Closed Network or the N.C. Medicaid program.
- Vaya issued two or more Plans of Correction against the Network Provider for the same or similar out-of-compliance findings, for example two findings related to lack of training (even if it referred to different trainings), within the fiscal year covered by the Contract.
- Vaya logged quality of care concerns, Level 2 or 3 incidents, or other serious grievances about the Network Provider that were not satisfactorily resolved in required timelines.
- The Network Provider has a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Vaya.
- The Network Provider did not respond (or did not timely respond) to requests for data or other information necessary for Vaya to respond to requests from the State or CMS.
- The Network provider fails to maintain and provide proof of insurance as required under the terms and conditions of the Contract.
- The Network Provider failed to meet Routine Monitoring requirements.
- The Network Provider routinely fails to satisfactorily complete and upload Service Authorization Requests (SARs) that meet Vaya UM requirements (i.e. high percentage of administrative denials proportional to the numbers of members served - generally anything higher than 10% is unacceptable).
- The Network Provider routinely fails to submit requests for SARs for continuation of currently authorized services at least 14 days prior to end of existing authorization – at least 75% of SARs must meet this standard.
- The Network Provider failed to implement an adequate emergency response system that complies with the requirements of contracted services, including the implementation of measures to respond to emergencies on weekends and evenings for members served by the Network Provider.
- The Network Provider routinely fails to meet DMH/DD/SAS access standards and appointment wait times or fails to comply with the no-reject policy for members referred by Vaya.
- The Network Provider did not meet or is unable to meet all re-credentialing requirements, including a failure to maintain any required facility or professional license.
- The Network Provider failed to cooperate and comply with discharge and transfer requirements to

ensure a smooth transfer for any member that desires to change providers, or because the Network Provider cannot meet his/her special needs.

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

- Efforts to satisfactorily implement an acceptable Cultural Competency Plan, including efforts to provide culturally competent services and ensure the cultural sensitivity of staff members.
- Efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes.
- Customer service and health literacy efforts to implement a system that ensures good communication with members and families.
- Evidence of cooperation with, and level of participation in, member and provider satisfaction surveys.
- Implementation of a robust Corporate Compliance Plan and Quality Management Plan with evidence of strategies and goals being implemented by the Network Provider.
- Evidence of adequate clinical leadership according to the disability and services being provided by the Network Provider with a sufficient supervision structure.
- Efforts to implement a HIPAA compliant Electronic Medical Record (EMR) system which supports management of authorizations and billing functions and compliance with the Federal Meaningful Use Standards;
- Demonstrated financial stability defined as having: (i) A minimum of one month's working capital or line of credit equal to the Network Provider's monthly gross income; and (ii) No tax liens.
- Demonstrated operations and information technology infrastructure in place necessary to meet all clinical, quality improvement, billing, and confidentiality standards required for providers of publicly-funded healthcare services, including but not limited to infrastructure necessary to monitor all financial information of the company such as debt to income ratio.

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

Section 3: Credentialing and Contracting

Introduction

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

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

Please note that Vaya will electronically send all credentialing and contracting applications, forms and correspondence to the latest contact email address provided to Vaya. In the event the address provided is not accurate, Vaya will make only one attempt to obtain a corrected address. **Please ensure that you promptly notify Vaya in the event of any change in your contact information.**

Overview of Provider Types

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

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

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

Licensed Practitioners are employed by a Comprehensive Care Center, CABHA, Agency, Hospital, or Group Practice that is fully contracted with Vaya. Licensed Independent Practitioners are directly contracted with Vaya to provide outpatient therapy to members. Whether working independently, in professional practice groups, or for large provider agencies or health systems, practitioners offer important access to outpatient care for members. All practitioners undergo rigorous credentialing to ensure the provision of high quality, evidence-based treatment.

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

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

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

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

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

Credentialing Initiation

The type of credentialing or re-credentialing application and verification process you must complete depends on your provider type and whether you are organized as an individual (sole proprietor) or a corporate entity, limited liability company (LLC), or partnership. Presently, we accept all credentialing forms, applications and other documentation via the following submission routes: electronic, facsimile, U.S. mail, courier service or hand delivery with receipt. Submitted applications must include all requested and/or required information or other documentation, and must be signed by the applicant no more than 180 days prior to the initial review of the application by the Vaya Credentialing Committee.

Vaya's dedicated Credentialing Hotline can be reached at 1-855-432-9139, or you may contact us at CredentialingTeam@VayaHealth.com. Our goal is to respond to all inquiries within 3 business days.

Credentialing Process for Entities

Within 5 business days following a determination that Vaya either: (a) approved the nomination of a new provider entity; or (b) approved the change request from a Network Provider seeking to add a new or additional site or service to their existing contract, the Credentialing Team will send the applicant an email that includes electronic access to the applicable application, instructions and contact information for technical assistance. Within 60 days of receipt of this email, the applicant must submit a complete credentialing application packet that includes the following information:

- An attestation statement that attests the application is complete and accurate, authorizes Vaya to collect any information necessary to verify the information in the application (including consent to

release social security numbers and dates of birth to verification entities and to consult with others who may have information bearing on the provider's competence and/or qualifications), signifies the provider's willingness to abide by Vaya policies and procedures, releases Vaya from liability related to the credentialing process, affirms that the provider is able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in Vaya's AlphaMCS billing process, and attests that the provider has a "no-reject policy" for referrals within the capacity and parameters of their competencies and agrees to accept all referrals meeting criteria for services they provide when there is available capacity.

- Identification of ownership of the entity, to include a list of all persons with an ownership or control interest of 5% or more ("owners") and a list of all parent, sister, affiliate and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company. The ownership identification must include the name, title, address, contact information, date of birth, and Social Security Number of any owners, directors (including members of the Board of Directors) managing employee(s) and fiscal agent(s) of the entity.
- Copy of the current license for each facility that is applicable for the requested service(s). A copy of the actual license must be included unless it can be primary source verified via the appropriate licensing agency website.
- Completed and signed W-9 Form.
- Identification of taxation status that includes type of business (not-for-profit, profit, partnership, etc.) and tax identification (ID) number.
- List of any Accreditations held.
- History of sanctions, probation or loss of accreditation or certification and disclosure of any actions that could result in a sanction, probation, or loss of accreditation or certification.
- History of names the entity has done business under or if business is using a "doing business as" name.
- Written documentation of Source of Authority through Charter, constitution, bylaws and/or Articles of Incorporation unless it can be primary source verified **OR** a Certificate of Authority that shows eligibility to do business in North Carolina unless it can be primary source verified.
- Organizational chart that includes all departments, divisions, units, program heads/ supervisors, and staff titles, as well as staffing patterns for each service for which the agency submitted an application.
- Certificate of Insurance or letter of intent from the agency's proposed insurance carrier that meets the minimum required amounts identified in the application.
- Professional liability claims history.
- Listing of Human Rights Committee members which include the names, title, and contact information (excluding Group Practices that only provide outpatient therapy services).
- Identification of any affiliation, by contract or otherwise, with any other NC Medicaid provider.

In order to decrease the administrative burden on hospitals/ health systems directly enrolled with DMA, we are permitted (but not required) to accept and rely upon DMA's credentialing of NC licensed hospitals. This may include all facilities and sites affiliated with the hospital/ health system seeking to be credentialed, to the extent such facilities and sites are enrolled with DMA and affiliated with the hospital/ health system in NC Tracks. Hospitals may complete and submit the full application described above, or may choose to submit a copy of

their DMA application. Vaya will review a hospital's completed DMA application against our accreditation and Waiver Contract requirements. Any required information not submitted to or verified by DMA must be submitted to Vaya for verification in accordance with the process outlined above. This includes but is not limited to social security numbers and dates of birth for all owners, directors, members of the Board of Directors and managing employees.

However, under our DMA Waiver Contract, we remain directly responsible for credentialing of all practitioners billing through the hospital/ health system. Hospitals and large group practices or agencies can choose to enter into a Delegated Credentialing Agreement (DCA) with Vaya for individual practitioner credentialing. In the absence of an executed DCA, all rostered hospital practitioners must complete the credentialing process described below prior to billing Vaya for services.

Credentialing Process for Practitioners

Practitioner Types

Vaya enrolls two different categories of practitioners: Licensed Independent Practitioners (LIPs) who directly contract with Vaya and are personally responsible for compliance with this Manual, and Licensed Practitioners (LPs) who work for, and bill through, another contracted provider such as an agency. LIPs must submit the Nomination form and meet selection criteria as outlined in Section 2 of this Manual. Network Providers may submit a Credentialing Initiation Form at any time to enroll new or additional LPs without going through the selection process, so long as the practitioners will be working out of a site that is already credentialed.

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

- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Specialist (LCAS)
- Licensed Psychologists – (Health Service Provider-Psychologist (HSP-P))
- Licensed Psychological Associate (LPA) – (Health Service Provider-Psychological Associate (HSP-PA))
- Licensed Psychiatrist (MD, DO)
- Licensed Psychiatric Nurse (RN)
- Advanced Practice Psychiatric Clinical Nurse Specialist
- Licensed Psychiatric/Family Nurse Practitioner providing MH/SA services under the supervision of a licensed psychiatrist (PNP or FNP) – must have psychiatric experience or experience working with the substance use population to apply as independent practitioner
- Licensed Physician Assistant (PA) providing MH/SA services under the supervision of a licensed psychiatrist
- Physician with substance use specialty or psychiatric training/experience (general physicians with no

substance use or psychiatric training are not eligible to apply)

- Nurse Practitioners (providing team based services as part of an agency)
- Physical Therapist (providing Specialized Consultative Services)
- Occupational Therapist (providing Specialized Consultative Services)
- Speech Therapist (providing Specialized Consultative Services)
- Board Certified Behavioral Analyst (BCBA - providing Specialized Consultative Services)
- Certified Therapeutic Recreational Therapist (providing Specialized Consultative Services)

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

Step 1 – Credentialing Initiation Form (CIF) and Council on Affordable Quality Healthcare (CAQH) Process

If an LIP is determined to meet selection criteria or a Network Provider submits a Provider Change Form identifying a new LP, Vaya will send a Credentialing Initiation Form (CIF) with instructions to the practitioner. The CIF is used to initiate the process of engaging the practitioner in the Council on Affordable Quality Healthcare (CAQH) on-line application process.

Nurse Practitioners who are seeking to be credentialed as LIPs must also submit a collaborative practice agreement (CPA) as part of their CIF. The CPA must describe the arrangement for continuous availability between the nurse practitioner and the supervising physician. The CPA should also describe the patient population being served, prescribing authority, drugs and devices that may be prescribed by the nurse practitioner, minimum standards for consultation between the nurse practitioner and the primary supervising physician, and the process for the annual review/re-signing of the CPA. Psychiatrists must identify completion of an approved/ accredited residency, and sub-specialty fellowship training must be documented (if taken). Residency is the period of clinical education in a medical specialty that follows graduation from medical school and prepares physicians for the independent practice of medicine. For physicians, this is the highest level of education and/or training required to be primary source verified by Delegate. Board Certification is not required; however, practitioners who identify themselves as board certified must do so in accordance with the definition of board certification for that recognized specialty board (i.e., for psychiatrists – The American Board of Psychiatry and Neurology).

The CIF and supporting documentation must be completed and submitted to Vaya within 60 days of receipt. If a completed CIF is not received within 60 days, the application will not be processed. If the CIF information is incomplete, inaccurate or conflicting, Vaya will electronically notify the practitioner of the information that is missing or incorrect. The practitioner's employer or a contact person with the employer may also be contacted to obtain additional information (if applicable). **For this reason, it is critical that the application contain accurate contact information.** If the practitioner does not return all necessary information within seven (7) business days of such notification, Vaya will provide a second electronic notification. If the practitioner does not

return all necessary information within seven (7) business days of the second notification, Vaya will not process the CIF and the practitioner must complete a new CIF.

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

Step 2 – Vaya Application Process

In order to complete the credentialing process, practitioners must submit a completed credentialing application packet which includes the following:

- Complete Council for Affordable Quality Healthcare (CAQH) Application.
- Name of Network Provider with whom LP is affiliated (does not apply to LIPs).
- Copy of initial and current license(s) renewal(s).
- Copy of initial and most recent board certification, if applicable.
- Copy of current DEA Certificate, if applicable.
- Certificate of Insurance or letter of intent from the practitioner's or agency's proposed insurance carrier that meets the minimum required amounts identified in the application.
- Professional liability claims history
- History of sanctions or pending actions that could result in sanctions
- History of loss or limitation of privileges or disciplinary activity.
- Identification of Hospital affiliations or privileges (if applicable) or name of practitioner to whom MD refers if lacking privileges.
- Past 5 years of relevant work history.
- Identification of languages spoken proficiently.
- Areas of specialized practice.
- Disclosure of any physical, mental, or substance use problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients.
- Copy of Educational Commission for Foreign Medical Graduate Certificate (if applicable), unless it can be primary source verified;
- Identification of the practitioner's on-call designee, who must be a member of the network or otherwise approved by Vaya, with the same credentials or higher.
- An attestation statement that attests the application is complete and accurate, authorizes Vaya to

collect any information necessary to verify the information in the application (including consent to release social security numbers and dates of birth to verification entities and to consult with others who may have information bearing on the practitioner's competence and/or qualifications), signifies the practitioner's willingness to abide by Vaya policies and procedures, and releases Vaya from liability related to the credentialing process.

- LIP Only – (1) An attestation statement that the LIP is able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in Vaya's AlphaMCS billing process; and (2) a complete and signed W-9 form.

Credentialing Verification Review

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

- Exclusions (OIG): http://exclusions.oig.hhs.gov/
- Exclusions (SAM): https://www.sam.gov/portal/public/SAM/
- National Practitioner Databank: https://www.npdb-hipdb.hrsa.gov/Login.jsp
- Social Security Death Master File: https://www.ssdmf.com
- NPPES: https://npiregistry.cms.hhs.gov/
- NC Tracks: http://ncmmis.ncdhhs.gov/taxonomy.asp
- NC Department of Revenue: http://www.dor.state.nc.us/collect/delinquent.html
- NC Secretary of State: http://www.secretary.state.nc.us/corporations/CSearch.aspx
- DHSR Facility Licensure: http://www.ncdhhs.gov/dhsr/mhlcs/facilities.html
- DHSR Provider Penalty Tracking Database: https://providertracking.dhhs.state.nc.us/
- DHSR Healthcare Personnel Registry: https://www.ncnar.org/verify_listings1.jsp
- DEA Certificates: www.deanumber.com
- NC Board of Licensed Professional Counselors (NCBLPC): http://www.ncblpc.org/license-info/verification(LPC).
- NC Marriage and Family Therapy Licensure Board: http://www.nclmft.org/public_resources/verify_a_licensee/ (LMFT)
- NC Social Work Certification and Licensure Board (NCSWCLB): www.ncswboard.org/ (LCSW)
- NC Substance Abuse Professional Practice Board (NCSAPPB): http://ncsappb.learningbuilder.com/Public/PractitionerLookup/Search (LCAS)
- NC Medical Board: http://wwwapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformationSearch.aspx
- NC Board of Psychology: http://www.ncpsychologyboard.org/search.htm
- NC Board of Nursing: http://www.ncbon.com/

- Criminal History: www.accuratebackground.com
- Joint Commission: http://www.qualitycheck.org/consumer/searchQCR.aspx
- CARF: http://www.carf.org/providerSearch.aspx
- Council on Accreditation: http://www.coanet.org/front3/page.cfm?sect=7&show=org&ctry
- American Board of Medical Specialties: http://www.abms.org/
- Foreign Medical Graduates: www.ecfmg.org

Any documentation submitted that is older than 6 months (or 1 year for facility licenses) will be denied during the verification process. If additional or corrected information or documentation is required, Vaya will electronically notify you of the specific information that is needed to complete the application. **As stated above, it is critical that the application contain accurate provider contact information.** Vaya's experience is that lapses in credentialing are primarily due to inaccurate contact information on file or failure to submit a complete application. If requested information is not returned within 7 business days of this notification, Vaya will provide a second electronic notification. If requested information is not returned within 7 business days of the second notification, the application will not be processed.

Once Vaya receives a complete application, the Credentialing Team will complete primary/ secondary source verification of information submitted, coordinate a Site Visit if required, and identify any flags that could impact the quality of care or services delivered to members.

Site Visits

For initial credentialing applications (including new sites), a site visit is required prior to completion of credentialing. Site visits are generally completed within 30 days of receipt of a complete application, and will be based on a standardized check sheet. In the event site visit criteria are not met, the applicant will be given 30 days in which to correct any deficiencies and undergo a final site visit. Failure to meet site visit criteria on the final visit shall result in the application not being presented to the Credentialing Committee.

Credentialing Committee Review

The Credentialing Committee is tasked with assuring that all agency, facility and practitioner applicants meet standards for entrance into the Vaya Provider Network. The Committee is made up of Vaya staff and local practitioners who are already members of the Vaya Provider Network and represents various licensing guilds. Based on the credentialing verification, a roster is prepared that identifies all providers and practitioners ready for presentation to the Credentialing Committee, as well as any flags identified and the details related to such flags that needs to be reviewed and discussed by the Credentialing Committee. All credentialing decisions are made by the Credentialing Committee, which is chaired by our Chief Medical Officer **and includes Network Provider representatives.** The Committee meets no less than monthly and delegated the approval of unflagged applicants to the Chief Medical Officer. An unflagged application is one in which there are no negative actions disclosed in the application, no negative findings were identified on reviewed databases, and the applicant meets good standing criteria, to the extent good standing can be determined at time of credentialing verification review.

Flags that may prompt further investigation or review include but are not limited to:

- Any identified deficiency related to good standing, including certain criminal history findings:
  - All felony and misdemeanor convictions within the last 5 years.
  - All felony and misdemeanor convictions that involve violence, sexual offenses, fraud or financial impropriety, regardless of age or time elapsed since the offense.
  - All convictions and pending charges for driving under the influence/ driving while intoxicated, regardless of age or time elapsed since the offense.
  - Traffic violations are not flagged unless the applicant has 3 or more guilty records for events that occurred within the twelve (12) months prior to the date of application.
  - Misdemeanors, including traffic violations, are presented to the Credentialing Committee in every case when additional flags are present.
  - Any felonies or misdemeanors that were not disclosed in the application.
- Gaps in employment of more than 6 months if gap is due to incarceration, inpatient admission, or refusal to explain.

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

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

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

Change Notifications

The data you provide during the credentialing process are used for referral purposes; therefore it is critical that you notify us as soon as possible if any of your information changes. All Network Providers must notify Vaya of any changes to the information presented in their most recent credentialing or re-credentialing application no later than 5 business days after the change using the Provider Change form available on Vaya's website: http://www.VayaHealth.com/credentialing/.

This includes but is not limited to changes to any of the following information:

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

In order to avoid any gaps in claim submission, Network Providers must notify Vaya of any changes in ownership or management, including but not limited to proposed acquisitions or mergers, as soon as practicable in advance of such change, but no later than 30 days prior to the planned change.

Requests to add a new or additional site or service must go through the process described in Section 2 of this Manual. Changes in capacity or inability to accept new referrals must be reported to providerinfo@VayaHealth.com or the Provider Help Line at **1-866-990-9712**. If you use the AlphaMCS slot scheduler, please notify Customer Services at 1-888-757-5726.

Independent Practitioners wishing to initiate a Leave of Absence from the Network must notify Vaya at least 60 days prior to their desired effective date, via email to providerinfo@VayaHealth.com. In the request, please identify the specific reason(s) for the request for a leave of absence (i.e. maternity leave, etc.). Vaya will generally approve requested leave for up to an initial 6 month period, with the option for an extension. An extension to the original leave should not exceed an additional 6 months and must be submitted no later than 60 days prior to the expiration of the original Leave of Absence.

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

Type of Change	Credentialing verification required?	Contract Amendment Required?
Phone Number	No	No
Primary Contact Person	No	No
Other Cover Sheet Contacts	No	No
Email or Website	No	No
Mailing Address	No	Yes
Billing Address	No	No
Site Address	Yes	No
NPI Number	No	No
Tax ID Number	Yes	Yes
Additional (New) Site or Service	Yes	No
Remove Site or Service	No	No
Practitioner Name	Yes	Yes if LIP
Practitioner License/ Certification	Yes	No, unless services also changing
Facility License	Yes	No, unless services also changing
Add or remove practitioner from roster	No	No
Withdrawal from network	No	Requires written confirmation of contract termination
Entity Name Change	Yes	Yes
Merger/ acquisition	Yes	Yes if name change to entity
Business license/ Entity type (i.e. NCSOS change)	Yes	Yes if name change to entity
Change in ownership percentages or removal of owner(s)	Yes	No
Add or remove owner(s)/ managing employee(s)	Yes	No

Emergent Change Requests

If needed in the event of a sudden and unexpected provider closure or to respond to a significant life, health or safety risk to a member, Vaya can process emergent change requests within 1 business day of the request. The applicable Provider Nomination or Provider Change form must be completed and submitted. In order to ensure timely processing, it is recommended that the requesting provider also call the Provider Helpline at 1-866-990-9712 or email providerinfo@VayaHealth.com to notify PN staff of the request and reason for emergent processing.

Re-Credentialing and Continuous Verification

All Network Providers, including practitioners, must be re-credentialed every 3 years. At least 180 days prior to the applicable re-credentialing expiration date, Vaya will provide you with electronic access to the applicable application, instructions (including deadline for submission) and contact information for technical assistance. **It is critical that you maintain accurate contact information with Vaya in order to avoid any lapse in credentialing.** If you do not submit a timely re-credentialing application or if your application contains errors or flags that require additional verification, your contract may be suspended on the date your credentialing with Vaya lapses, and may not be reinstated until your re-credentialing is approved. During the re-credentialing process, you must sign a release of information and liability that allows Vaya to make inquiries into your background, including questions regarding criminal history, physical and mental health status and lack of impairment due to chemical dependency/substance use, loss or limitation of privileges and/or disciplinary activity and current malpractice coverage.

The process for re-credentialing is virtually identical to initial credentialing. However, applications for re-credentialing must update any information that changed since the previous credentialing. Providers who entered the network during the "Open Enrollment" process may have to provide additional information or meet higher standards during the re-credentialing process. Be aware that the following conditions can affect your credentialing status (this is not an exhaustive list):

- Loss of good standing status;
- The Vaya Contract Performance Unit, Special Investigations Unit, Quality Improvement Team or other Vaya staff report that you breached a material term of your contract with Vaya that is subsequently substantiated;
- The Credentialing Committee determines that your general area of practice or specialty involves experimental or unproved modalities of treatment, or therapy not widely accepted in the medical community;
- Vaya receives a credible report of inappropriate contact with a patient of a sexual or amorous nature, or violation of other clinician/member boundaries

Vaya maintains standards for practitioner participation that ensure competent, effective, and quality care to our members. Vaya reserves the right to suspend or terminate a practitioner's credentials, or take other action as

deemed necessary, for activity, actions, and/or non-actions which are contrary to accepted standards of medical practice or the requirements of your contract. Stability of past operations is important. An assessment of the applicant's record of services, compliance with applicable laws, rules, regulations and standards, the qualifications and competency of any staff, the satisfaction of members and families served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems will be evaluated by the LME/MCO prior to enrollment to the extent possible and at regular intervals thereafter through Routine and Focused Monitoring. During this process, you may be asked to demonstrate your system of communication with members and how members and families are involved in treatment and services.

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

We continuously review available databases against our roster of credentialed providers, practitioners, owners and managing employees. Exclusion databases are monitored monthly on a monthly basis. State licensing boards, National Practitioner Data Bank (NPDB), National Technical Information Service and NC Department of Health and Human Services are monitored no less than quarterly. Vaya reserves the right to monitor more frequently and to monitor other databases not listed above. Any flags identified through such continuous verification will be brought to the Credentialing Committee for review and decision.

Disciplinary actions that can be taken by the Chief Medical Officer and/or full Credentialing Committee related to credentialing include but are not limited to a Letter of Censure, Site Visit, Probation/ Increased Monitoring, Plan of Correction, Contract Suspension, Suspension of Referrals, Revocation of Credentialing Status, and Exclusion. We also reserve the right to suspend a practitioner for up to 15 business days pending review by the Credentialing Committee/Credentialing Specialist where potential adverse medical outcome will affect a patient or the general patient population.

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

Contracting

All Network Providers must execute a written agreement with Vaya before any services can be authorized or reimbursed. These agreements must be in your official legal name, as identified on the NC Secretary of State database (for entities) or other legal form of identification (for independent practitioners).

Vaya no longer utilizes “evergreen” contracts with no end date. All provider contracts are now on the State FY cycle, from July 1 to June 30 of each year. Vaya utilizes a unified contract template to ensure consistency across the Closed Network. The template does not include an attachment with a specific list of approved sites, services and codes. This eliminates the need for a contract amendment every time a change is made. Instead, providers must verify that accurate sites, services and codes were correctly entered into Vaya’s AlphaMCS system. Vaya’s Contracts Team can generate a report upon request that lists all sites, services and codes associated with your Contract in AlphaMCS. **Note:** Vaya must approve provider requests to add new billing sites or services prior to the delivery of any new services or services rendered from new sites. Providing new services and/or rendering services from a new site that is NOT approved, credentialed and incorporated in AlphaMCS will result in denied claims and/or adverse action.

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

We utilize DocuSign®, a web-based platform that provides electronic signature technology and Digital Transaction Management services for facilitating electronic exchanges of Vaya Contracts and signed documents. DocuSign® is legal, administratively efficient and automatically provides you with a scanned copy of your executed contract following execution. It enabled Vaya to lower administrative costs, reduce contracting process timeframes, improve the tracking of executed contracts, and ensure that the vast majority of contracts are executed prior to their effective date.

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

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

Out-of-Network Agreements

In situations where Vaya determines that our Closed Network cannot meet the need for geographically accessible, appropriate and/or timely services for a specific member, we may identify a selected out of network provider to meet the need. Completing the abbreviated verification process described in this section does not mean the provider is a member of Vaya’s Closed Network. The first step is to complete the Out of Network Agreement Request via DocuSign®, which is found on the provider enrollment page of Vaya’s website at: http://vayahealth.com/providers/enrollment/. If the request is approved and all necessary information is

submitted, Vaya will review and/or verify the following limited credentials necessary for successful claims adjudication and to ensure the health, safety and welfare of members, as applicable to the provider type:

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

These verifications are not presented to the Credentialing Committee for review unless a flag is identified. If approved, the Agreement will proceed to final processing and execution. Providers who are serving multiple members under an Out of Network Agreement, or who executed more than two Agreements in a fiscal year will be invited to apply for membership in the Closed Network.

Section 4: Access to Care

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

No Wrong Door

Vaya follows a "No Wrong Door" approach to eligibility, enrollment and access to care. This means that members can access services through our Call Center or by contacting a Network Provider – there is no wrong door to access treatment. All Network Providers are required to complete eligibility determinations and request enrollment of an eligible individual into a Vaya Health Plan. Vaya's Comprehensive Care Centers offer same day access for triage and/or assessment at offices located in each of our 23 counties. Network Providers may conduct screening, triage and referral following the process and criteria outlined below, or may link individuals requesting services to Vaya's Access to Care line at **1-800-849-6127**. **In either case, all Network Providers are required to meet the applicable DMH/DD/SAS access to care timeframe based on a classification of the request as Emergent, Urgent or Routine.**

Eligibility

Individuals whose services are paid for in whole or in part by Vaya must meet eligibility criteria for a Vaya Health Plan. If you have any questions about whether someone is eligible for a Vaya Health Plan, please call the Enrollment and Eligibility (E&E) team at 828-225-2785 Ext. 2355. You can also email the E&E team at EandE@VayaHealth.com or call Customer Services at 1-800-757-5726.

1915(b) Medicaid MH/DD/SA Health Plan: Individuals who receive a qualifying category of Medicaid from Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes or Yancey counties are automatically a member of the MH/DD/SA Vaya Health Plan. In general, to be eligible for Medicaid coverage, the individual must:

- Be a U.S. citizen or provide proof of eligible immigration status; AND
- Be a resident of North Carolina and provide proof of residency; AND
- Have a Social Security number or applied for one; AND
- Meet Category of Aid eligibility criteria as determined by the county Department of Social Services (DSS) office where the individual resides.
- NOTE: Individuals currently receiving Supplemental Security Income (SSI) benefits, Special Assistance

to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled are automatically eligible for Medicaid and do not need to apply at DSS.

*Some Medicaid Categories of Aid are not covered under the Vaya Health Plan and remain under the N.C. Division of Medical Assistance (DMA). Qualifying Categories of Aid are listed below:

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

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

1915(c) Innovations Waiver Health Plan: An individual must meet all of the following eligibility criteria and be enrolled in the Innovations Waiver in order to receive these services:

- The individual is eligible for Medicaid coverage, based on assets and income of the applicant (not including family resources) whether he/she is a child or an adult.
- The individual's residence, for purposes of Medicaid eligibility, is within one of Vaya's 23 catchment area counties.
- The individual is assigned a Waiver "slot."
- The individual meets the requirements for ICF-IID level of care as approved by the Vaya Care Management Team.
- The individual lives in an ICF-IID facility or is at high risk for placement in an ICF-IID facility. High risk for ICF-IID institutional placement is defined as a reasonable indication that individual may need such services in the near future (one month or less) in the absence of Home and Community Based Services.
- The individual's health, safety, and well-being can be maintained in the community through a combination of Waiver and natural supports.
- The individual qualifies for Innovations Waiver services, i.e. the services are medically necessary and appropriate for the individual. The individual must use at least one Waiver service per month for eligibility to be maintained.
- The individual, his/her family, or guardian desires participation in the Innovations Waiver program

rather than institutional services.

- NC Innovations Waiver participants must live in a private residence, with family, or in a living arrangement with six or fewer persons unrelated to the owner of the facility.

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

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

Enrollment

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

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

- Determine if the member is eligible for Vaya's Non-Medicaid Health Plan as outlined above.

After eligibility is established, Network Providers are required to enroll individuals for services without prior screening, triage or referral by Vaya. If the individual has Medicaid or was previously enrolled in a Vaya Health Plan, he or she may be eligible for publicly-funded services through Vaya. If the individual was previously enrolled in a Vaya Health Plan, but claims for services were not submitted for more than 90 days, you must complete a new enrollment. If the individual is not yet enrolled, then you must obtain and submit all data necessary to do so. Required data elements are identified in the Vaya Claims Manual & Billing Guide, and include Medicaid ID number if applicable, date of birth, and identification of any other third party payor, including Medicare. It is your responsibility to ensure that enrollment data is accurate and up-to-date. If enrollment data is not accurate or complete prior to service provision, your ability to successfully submit authorization requests and claims may be impacted.

Member enrollment must be performed electronically through AlphaMCS. Enrollment can be verified by contacting the Access Center at 1-800-849-6127. Detailed instructions and timeframes for completing an enrollment request can be found in the Claims Manual & Billing Guide. You must complete the eligibility determination and enrollment request prior to service provision, except for crisis services provided in a documented emergency. Claims submitted for services provided prior to date of enrollment will be denied.

Customer Services/ Call Center

The Customer Services department operates a toll-free Access to Care line 24 hours a day, 7 days a week, 365 days a year for telephonic screening, crisis intervention and appointment referrals for people seeking assistance with mental health, substance use, and intellectual/developmental disability issues. **This number is 1-800-849-6127.** The Access to Care line is answered by a live person, generally within 30 seconds. During times of heavy call volume, overflow calls may be automatically redirected to Partners Behavioral Health Management or Cardinal Innovations for Call Center back-up.

Customer Services also provides our members and communities with general information via a separate toll-free Customer Services line that is available 8:00 am – 5:00 pm on regular business days. This number is 1-888-757-5726 and can be used to report a compliment, complaint or concern about Vaya or any of our Network Providers. The Customer Services department is staffed by Customer Services Representatives (CSRs) and Customer Services Clinicians:

- CSRs are bachelor level or non-licensed Qualified Professionals with at least two (2) years experience in the human services field. Their primary job responsibilities are to answer the telephone calls coming in to the Access to Care Line, collect demographic information, verify insurance eligibility, and complete a brief intake screening to determine the type and level of service/s most appropriate for callers. CSRs can also provide information about community resources, provide information about inpatient facilities, when appropriate, and follow up to assure members discharged from inpatient facilities are engaging in the next level of care.

- Customer Services Clinicians are Master's Prepared Licensed Professionals who handle emergency and crisis intervention calls as well as regular CSR duties. The Customer Services Clinicians follow all requests for emergency services until it is established that contact with a mobile crisis management (MCM) provider, first responder or other provider is made. Customer Services Clinicians are available to take over calls with members who are in distress.

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

- Crisis intervention, including referral to Mobile Crisis Management
- Manage and provide referrals for Urgent and Emergent Calls
- Referrals for Diagnostic or Comprehensive Clinical Assessment
- Information about community (non-treatment) resources
- Enrollment of an individual into a Vaya Health Plan
- Eligibility questions
- Document complaints or grievances and route the information to the QM department for resolution
- General information about Vaya and the public MH/IDD/SUD services available in our catchment area

Screening, Triage and Referral Process

If the Member contacts Vaya's Call Center: If a caller does not request clinical assessment or treatment services, the CSR will offer suggestions for obtaining natural supports and/or community services. If a caller requests clinical assessment or treatment services, the CSR will gather demographic information and determine whether risk indicators are present that necessitate involvement of a Clinician. If the call involves no risk indicators, the CSR offers choice of available Network Providers and links the caller to the selected provider for an intake appointment. When risk indicators are identified, the CSR involves a Clinician to determine the most clinically appropriate referral and the clinical urgency with which the caller should be seen by the referred provider: Emergent, Urgent or Routine.

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

Potential Risk indicators include but are not limited to the following:

- Report of harm to self or others or property destruction

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

Screening, Triage and Referral Criteria

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

- The member has a current significant risk related to safety or supervision, as evidenced by:
  - Risk of harm without supervision, such as walking into traffic or wandering
  - Current harm without supervision
  - Impaired reality testing, such as delusions, hallucinations
  - Dangerous disruptive or bizarre behavior
- The member presents current significant risk of harm to self or others, as evidenced by:
  - Verbalized or implied threats to physically harm self or others
  - Verbalized or implied plan to physically harm self or others
  - Active cutting or burning self
  - Current self harm or of harm to others
- The member has severe incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SUD issue(s), such as:
  - Actively psychotic with impaired self-care functions, as in unable to care for self on a daily basis regarding food, hygiene, toileting, etc.
  - Bizarre thought processes
  - Recent physical, cognitive, or behavioral incapacitation related to MH/IDD/SUD issue(s)
- The member indicates multiple withdrawal symptoms or reports a history of severe withdrawal and current/recent heavy use, or recent referral for detoxification. Symptoms include tremors, paroxysmal sweats, anxiety, agitation, tactile disturbances (itching, bugs crawling, pins, burning sensations), auditory disturbances, visual disturbances (e.g. light sensitivity, seeing things not there), headache, disorientation regarding date, and/or inability to do simple math (additions).

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

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

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

Urgent Services may be provided through an outpatient clinic or office, through a Walk-In Service, or by a Mobile Crisis Management Team.

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

- The member has mild to no risk related to safety or supervision, as evidenced by ability to care for self on a daily basis.
- The member presents no risk of harm to self or others, as evidenced by denying any thoughts or plan of harm to self or others.
- The member has mild to moderate incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SUD issue(s). An example is member's mental health symptoms cause distress but are not currently incapacitating.
- The member shows no indicators of significant risk for substance abuse withdrawal symptoms as evidenced by:

- Mild agitation, anxiety, or depression
- Member reports minimal recent use or no substance use within the past several days
- No history of significant withdrawal
- Member demonstrates motivation for treatment by agreeing to attend 12 step support during period prior to assessment

Routine Services may be provided through a variety of outpatient or clinic settings, or through a Walk-In center.

DMH/DD/SAS Access to Care Timeframes

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

- Emergent: This standard requires a face-to-face clinical assessment and intervention to be started within two hours of communication of the service request to the referred provider.
- Urgent: This standard requires a face-to-face clinical assessment and intervention to be started within 48 hours of communication of the service request to the referred provider.
- Routine: This standard requires a face-to-face clinical assessment and intervention to be started within 14 calendar days of communication of the service request to the referred provider.

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

Referrals and Appointments

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

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

Medical Transportation Services

Throughout Vaya's rural catchment area, members need transportation assistance in order to access services. As a Network Provider, you must assist members you serve in accessing available public transportation as well as medical transportation available through county Departments of Social Services. DSS transportation is for medical (including MH/IDD/SUD) appointments or picking up prescriptions at a pharmacy. Riders must call 2 to 4 days ahead to arrange a ride. There is no fee for Medicaid beneficiaries. For those who are not enrolled in Medicaid, transportation depends on available space, and there is a fee. Unfortunately, there are no publicly funded medical transportation services in the evening or on weekends.

Section 5: Billing and Reimbursement

This section provides a high-level overview of the provider billing and reimbursement process. We are also developing a Claims Manual & Billing Guide ("Claims Manual") that will provide more detailed information than what is contained in this Manual. For questions about claims or reimbursement issues, please contact us at 828-225-2785 Ext. 2455 or Claims@VayaHealth.com.

Billing Prerequisites

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

- **Enrollment and Member ID:** As explained in Section 4 of this Manual, the individual must be eligible for and enrolled in a Vaya Health Plan in order for a claim to be processed. The Member ID Number identifies the specific individual receiving the service and is assigned by the AlphaMCS information system. In order for the Provider to obtain this number, the individual must be successfully enrolled into a Vaya Health Plan. All claims submitted with incorrect Member ID numbers, or for members whose enrollment is no longer active, will be denied.
- **Medical Necessity:** All services paid with public funds must meet documented medical necessity criteria.
- **Prior Authorization:** As outlined in Section 6 of this Manual, certain services must be authorized by Vaya prior to service delivery and claims submission. Vaya's claims adjudication system is specifically designed to verify authorization and other eligibility edits prior to reimbursement.
- **Coordination of Benefits:** Vaya is the payor of last resort. All other available first and third party payment must be exhausted prior to billing Vaya for services rendered. If the member is eligible, state funds must be exhausted prior to billing Medicaid.
- **NPI (National Provider Identifier) and Taxonomy:** All providers are required to obtain an NPI number to submit billing on the CMS1500 and UB04 forms. Best practice for successful claims submission is to obtain a separate NPI number for each site from which services are billed. Accurate NPI numbers and taxonomy codes are required for claims to be accepted and processed. Failure to comply with these guidelines may result in denied claims and/or recoupment of previously paid claims.
- **NC Tracks:** Network Providers are responsible for ensuring that provider names, billing addresses, site addresses, NPI numbers and taxonomy information submitted to Vaya are verified and accurate and exactly match the information in the State of North Carolina's Medicaid Management Information System (MMIS), which is known as "NC Tracks." Failure to adhere to this requirement may result in claims denial or recoupment.
- **Documentation and Service Delivery Requirements:** Network Providers are responsible for ensuring that services are delivered and documented in accordance with Controlling Authority outlined in your Contract, including but not limited to DMA Clinical Coverage Policies and the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Please be aware that Medicaid regulations do not allow payment for services delivered to inmates of public correctional institutions or for people

admitted to facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMDs). This may include some state facility, private hospital, Adult Care Home and Family Care Home settings. It is your responsibility to know whether a member is admitted to an IMD at the time of service delivery.

- **Clean Claims Requirement:** A clean claim is defined at 42 CFR § 447.45 as one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in Vaya's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. It is your responsibility to ensure that all claims submitted to Vaya meet this definition.
- **Electronic Funds Transfers (EFTs)**: All reimbursement to Network Providers is done through EFT. Vaya does not write paper checks to Network Providers. It is your responsibility to ensure that Vaya has accurate EFT, tax ID and W-9 information on file prior to claims submission.

Authorization Specifics

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

Claims Submission

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

- Basic Benefit Services, Outpatient Therapy, Enhanced Services, Innovations Waiver Services, non-Medicaid Residential and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or the electronic CMS 1500 form if billing through the AlphaMCS Provider Portal.
- Inpatient, Therapeutic Leave, Medicaid-funded Residential Services, Outpatient Revenue Codes and ICF-IID Services must be submitted using the ANSI 837I (Institutional) format or the electronic UB04 form if billing through the AlphaMCS Provider Portal.
- Paper claims will only be accepted from Out of Network Hospitals or Physician Groups who submit claims for services delivered in an emergency department setting. These providers will be required to submit an accurate CMS1500 or UB04 billing form with the correct data elements.

Timeframes: In general, all claims must be submitted within 90 days of the date of service or discharge, unless otherwise specified in your contract. Claims where Vaya is the secondary payor must be submitted within 180 days of the date of service or discharge date. Upon official notification of retroactive Medicaid eligibility by NC DHHS, a provider must complete at least one of the following activities within 45 days: submit a member eligibility update, submit a service authorization request, or submit a claim for service to Vaya. Providers are permitted 90 days from the date of service in which to file a claim. In the case of retroactive Medicaid eligibility, the timely filing requirement of ninety days will be measured from the date that member eligibility is determined by NC DHHS, and not from the effective date of eligibility, unless the notification occurs less than 45 days from the date of service. Claims submitted outside of these timeframes will be denied. Claims must be submitted no less than monthly. Network Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule in conjunction with the checkwrite schedule available on our website.

837 File Submission: Network Providers who wish to submit using an 837 file must complete training, successfully submit and receive test files, and execute a Trading Partner Agreement. The process is outlined at: http://www.VayaHealth.com/documents/providers/billinfo/Steps_For_837p_And_837i_Testing_And_Approval_2015-04-02.pdf. Training is available at http://etraining.VayaHealth.com/. Detailed instructions for 837 file submission are provided in the HIPAA Transaction Professional (837P) and Institutional (837I) Transaction Companion Guides, which explain entire testing and approval process. HIPAA compliant American National Standards Institute (ANSI) transactions are standardized; however each payor can exercise certain options and require use of specific processes. The purpose of the Companion Guide is to clarify those choices and requirements so that Network Providers can submit accurate HIPAA transactions. Vaya provides the following HIPAA transaction files back to Providers: 999 (an acknowledgment receipt), 824 (a line by line acceptance/rejection response), and 835 (an electronic version of the remittance advice).

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

their billing systems.

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

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

- Current Procedure Terminology (CPT) codes and modifiers
- Healthcare Common Procedure Coding System (HCPCS) codes and modifiers. Note that HCPCS includes specific requirements regarding unit billing. For example, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers should bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed.
- CMS Uniform Billing Revenue codes and modifiers (UB04 submission)
- Place of Service Codes
- ICD-10 Diagnosis Codes: ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. Diagnosis codes from the ICD-10 Code Manual must be provided to the highest level of specificity and follow the classification and diagnostic tools found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013 (DSM-V). Implementation of the ICD-10 Code Manual by Vaya Network Providers was required effective October 1, 2015.

For more information about coding and ICD-10 implementation, please see http://vayahealth.com/providers/accurate-timely-payments/claims/.

Coordination of Benefits

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

pursuant to a custody order, liability judgment (e.g. vehicle accident), etc.

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

You must bill all first and third party payors and make reasonable efforts to collect all first and third party funds prior to billing Vaya for services. You must wait a reasonable amount of time in order to obtain a response from the first or third party payor before billing Vaya. You are required to retain copies of the Electronic Remittance Advice (ERA), Explanation of Benefits (EOB) or other proof of payment or denial from the applicable payor and record on the claim either the payment or denial information. Claims must identify the amounts collected from both first and third parties and only request payment for any remaining amount. If the member is eligible for non-Medicaid services, those funds must be exhausted prior to billing Medicaid. The Vaya AlphaMCS System can validate third party payors and deny or adjust the claim. For Out of Network hospitals and physician groups permitted to file paper claims with Vaya, the provider is required to submit copies of the ERA or EOB with the claim form to Vaya. If you receive reimbursement from a first or third party after a claim is submitted to Vaya, you must notify us and submit reimbursement within 30 days of receipt of the first or third party funds.

Under the 1915(b) waiver, Network Providers are not permitted to charge a co-payment to Medicaid-eligible members for services. Once you accept referral of a Medicaid beneficiary from Vaya, you must accept Medicaid reimbursement as payment in full for the services (other than legitimate first and third party payments). You may not charge a Medicaid beneficiary for services delivered under your Contract with Vaya if we deny authorization or reimbursement. If you collected funds from Medicaid beneficiaries for any services delivered under your Contract with Vaya, you must notify Vaya and return all funds received from the member or responsible party immediately.

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

Household Income	**Fee**
Individuals whose household income falls under 100% of Federal Poverty Guidelines (FPG)	No co-payment or fee
Individuals whose household income falls between 100 and 200% of FPG	$1.00 co-payment per service or visit*
Individuals whose household income falls between 200 and 250% of FPG	$2.00 co-payment per service or visit*
Individuals whose household income falls between 250 and 300% of FPG	$3.00 co-payment per service or visit*

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

Remittance Advice and Claims Inquiries

The Remittance Advice (RA) is the standard method of communicating back to providers exactly how each and every claim is adjudicated. RAs will be available in the Download Option of the AlphaMCS system following each check write, and will report whether claims are approved or denied and the reason code for each denial. HIPAA regulations require Vaya to supply providers who submit 837 files with an electronic Remittance Advice known as the 835. The 835 will electronically report claims status and payment or denial information.

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

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

Repayment of Funds Owed to Vaya

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

The Social Security Act and your Contract requires you to notify us in writing of any Medicaid claims reimbursed by Vaya that must be repaid, whether due to fraud, waste, abuse or error, within five days of identification of the improper reimbursement. You must remit the overpayment within 60 days of identification of the improper reimbursement. You must either file a void claim or replacement claim, or you may choose to complete a Claims Adjustment Request Form. The form and instructions are posted at http://www.VayaHealth.com/claims.asp, under Forms and Templates. Upon receipt of the form, Vaya will make adjustments in the system and those adjustments will appear on your next RA.

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

If you receive a written Notice that Vaya identified an overpayment based on fraud, waste, abuse, overutilization or non-compliance with your Contract, including Controlling Authority, you must remit the amount owed within 30 days of the Notice, unless you submit a timely request for reconsideration as outlined in

Section 17 of this Manual, or request in good faith a payment plan. If you fail to timely file a request for reconsideration or fail to timely submit requested financials and/or agree to a payment plan within a reasonable time after requesting a payment plan, we may recoup the funds owed from your claims payments without further notification. We are not required to approve any request for a payment plan. All payment plans will require a signed agreement and may require a Promissory Note and security.

Section 6: Benefit Plans and Authorization

Medicaid – The NC MH/DD/SAS Health Plan (1915(b) Waiver)

Vaya's Medicaid MH/IDD/SUD Benefit Package includes all behavioral health services required by the 1915(b) Waiver and the NC State Plan for Medical Assistance. Vaya's Medicaid 1915(b) Benefit Plan is available on our website at: http://vayahealth.com/providers/managing-care/authorizations/.

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

Innovations – The NC Innovations Waiver Health Plan (1915(c) Waiver)

NC Innovations is a 1915(c) home and community based services (HCBS) waiver. Vaya's Innovations Waiver Benefit Package includes all services required by the 1915(c) Waiver and NC DMA Clinical Coverage Policy No: 8P: https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/8p.pdf. Vaya's Medicaid 1915(c) Benefit Plan is available on our website at: http://vayahealth.com/providers/managing-care/authorizations/.

Non-Medicaid Benefit Plan

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

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

Prior Authorization

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

- Outpatient Therapy (including group). —*This does not include Home-Based Therapy or non-Medicaid Individual & Family Therapy, which do require prior authorization.*
- Psychological Testing — Prior authorization is not required for up to 8 units for adults and up to 16 units for children in any 12 month period. After these limits are reached, prior authorization is required. *However, prior authorization is still required for psychological testing paid for with non-Medicaid funds.*
- Mobile Crisis Management Services – first 8 hours per episode of care do not require authorization
- Inpatient Services – first 72 hours per episode of care do not require prior authorization
- Facility Based Crisis Services – first 7 days per episode of care do not require prior authorization
- Substance Abuse Intensive Outpatient Program (SAIOP) – first 30 days per calendar year do not require prior authorization
- Supported Employment/Long Term Vocational Services – Non-Medicaid Long Term Vocational Support and Supported Employment services require no prior authorization for the first 64 units (16 hours) of SE/LTVS services for the initial engagement of the individual (for both SE and LTVS phases). Authorization for continued services must occur after the 64 units, and services may cover up to 12 months for the initial authorization period. To continue SE/LTVS, reauthorizations should be based on the level of intensity required to acquire stable employment or interventions required for continued employment. *Note that Medicaid beneficiaries must access Medicaid B3 Supported Employment, which does require prior authorization, rather than Non-Medicaid Supported Employment.*
- (b)(3) Peer Support – Prior authorization is not required for group or individual.
- Codes specifically agreed upon by Vaya and provider which are listed as “No Auth Required” under your Contract with Vaya. Please see your contract for applicability.

All other services require prior authorization. Before requesting authorization for services, the first step is to complete a comprehensive clinical assessment addressing the elements required by DMA Clinical Coverage Policy.

Provider Responsibility: Requesting authorization, supporting the request with required documentation and demonstrating medical necessity is the responsibility of the provider who will be delivering the service. All providers must use the electronic AlphaMCS Service Authorization Request (SAR) form to request prior authorization. Vaya can only process a complete, valid request. If the form is not completed fully, including all required administrative and clinical information, the SAR may be returned, delayed or denied. Vaya staff may refer Network Providers who routinely fail to timely and fully complete SARs for investigation, as this directly impacts continuity of care for the members we serve. Requesting authorization is the responsibility of the provider who will be delivering the service. Please note that providers cannot request authorizations on behalf of another provider. Behavioral Health Clinical Home providers generate and submit the service plan for all services for a given member, but may request authorization only for those services that they provide.

How do I complete and submit a Service Authorization Request (SAR)?

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

When do I submit a Service Authorization Request (SAR)?

- Initial Requests – SARs must be submitted at least fourteen (14) days prior to the requested start date of services, except for inpatient or other expedited requests.
- Periodic Services – For routine services, requests to renew an existing authorization must be submitted at least fourteen (14) days prior to the end of the previous authorization in order to avoid a gap in authorization or payment. It is your responsibility to submit a SAR for each subsequent service authorization request prior to the expiration of the current authorization, and to conduct a clinical review of the member's ongoing need for services.
- **All Network Providers are required to submit at least 85% of initial and continuing requests more than 14 days before requested start date or end of prior authorization, except for requests that meet criteria for expedited review and for emergent/ urgent services.**
- Inpatient and Facility Based Crisis Authorizations – if continued authorization is requested, the request and supporting documentation must be submitted to Vaya 24 hours prior to the lapse of the current authorization, unless the renewal date falls on a weekend or holiday when the request may be submitted the next business day for retrospective review.
- Retrospective Requests – In situations where the beneficiary did not have Medicaid at the time the service was provided but later obtains Medicaid eligibility with an effective date that encompasses the dates that the service was provided, the SAR and all associated documentation must be submitted no later than thirty (30) days following notification of the Medicaid eligibility determination. Any authorization information from a different vendor or LME that were applicable during the period of services to be reviewed should be included with the request.

When can Vaya return a SAR as unable to process?

Vaya can only process SARs if we receive a complete, valid request. If any of the following information is missing,

incomplete or incorrect, we will return the SAR as unable to process. Note that many of these elements are required fields in the electronic SAR.

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

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

- Identical or Duplicate request, i.e. the provider submits two requests for the same service/ same dates for a member OR two different providers submit the same request for the same member, in which case Vaya will process the first request received and return the second request as unable to process
- Member not enrolled in a Vaya Health Plan
- Inconsistent or conflicting information in the request and supporting documentation, i.e. name and MID do not match
- Diagnosis or service not covered by applicable Benefit Plan, i.e. you submit a request for a non-behavioral health service that is only covered by DMA (e.g. radiology)
- Requests submitted more than 30 days prior to the requested service start date, except for Innovations Waiver services which can be submitted up to forty-five 45 days prior to the start date
- Funding is not available for a non-Medicaid or (b)(3) service
- Service does not require prior authorization

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

Supporting Documentation: You are responsible for understanding what documentation is required to be submitted with a SAR. This information can be found in the Medicaid Waiver, applicable DMA Clinical Coverage Policies and DMH/DD/SAS Service Definitions, and other references listed on the Authorization section of our website: http://www.VayaHealth.com/authinfo.asp. Requests that are missing required information may result in an administrative denial, which means there is no clinical review but the member receives a notice with appeal rights. In addition to required documentation, Network Providers are strongly encouraged to submit any and all information that will support a finding of medical necessity. We will consider all relevant information that is submitted. Our experience is that many providers wait to submit required or helpful supporting information until after a denial was issued. This delays care for members and creates more work for you and Vaya.

Service Plans: Some services require the development and submission of a service plan. Approved plan formats include the Person-Centered Plan (PCP) and Individual Support Plan (ISP), used with Innovations Waiver participants. For members receiving MH/SA services, plans must be submitted by the Behavioral Health Clinical Home Provider. If a member you are serving does not have a Behavioral Health Clinical Home, then you must

collaborate with other providers in developing the service plan. For Innovations Waiver participants, the plan is submitted for approval by the assigned Vaya Care Coordinator. Service plans must be submitted to Vaya upon development of the initial plan following the initial assessment, at least annually thereafter, and whenever significant changes occur in the member's situation and/or plan of care, including all changes to recommended services.

Level of Care/ Placement Criteria: Vaya requires that all SARs include results from the following clinical decision support tools as applicable to the member or service being requested:

- Level of Care Utilization System (LOCUS©) for individuals age 18 and older, and Child & Adolescent Level of Care Utilization System (CALOCUS©) for children ages 5 to 17. The LOCUS© and CALOCUS© are assessments and placement instruments developed by the American Association of Community Psychiatrists (AACP) with input from the American Academy of Child & Adolescent Psychiatry (AACAP). As of February 1, 2013 these assessment tools must be used to assess level of care for individuals with mental health, emotional or behavioral health needs and are required for all SARs submitted to Vaya. For more information about these tools, please see http://www.locusonline.com/.
- Child & Adolescent Needs and Strengths (CANS-MH) is used for children under age 5 with mental, emotional, behavioral health or intellectual/ developmental disability needs. For more information about the CANS tool, please see http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/.
- NC Support Needs Assessment Profile (NC-SNAP), which is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for I/DD supports and services. The NC-SNAP was developed by DHHS and officially adopted in 1999 as the requisite tool for determining an individual's intensity of need for I/DD services. As part of the shift to the Resource Allocation model, Vaya and other MCOs are in the process of phasing out the use of NC-SNAP in favor of the SIS®.
- Supports Intensity Scale® (SIS) is a tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) that measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS® was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. All Vaya SIS® assessors are trained by AAIDD in administration of the SIS®. Effective November 1, 2016 all Innovations Waiver participants must have a valid (performed within the last 3 years) SIS® score in place as part of the annual plan of care approval process. For more information about the SIS, please see Section 13 of this Manual or http://aaidd.org/sis#.Vgf895d5-OY.
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC), which are the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with substance use/ addiction and co-occurring conditions. For more information about ASAM criteria, please see http://www.asam.org/publications/the-asam-criteria.
- NOTE: Completion of one of the above approved leveling tools is required even for services that do not require prior authorization.

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

If we ask for more information, you will have up to 3 days to submit the additional information. If the request contains all required information, we will review to determine if medical necessity criteria are met. All requests for Medicaid members under age 21 are also reviewed against EPSDT criteria (discussed below). We will never ask you to withdraw or modify a request, although you may decide to do so at any time if you decide there is a different service that would be more clinically appropriate.

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

Peer Review: If a Care Manager is unable to approve a request based on medical necessity or EPSDT, it will be referred to a licensed Ph.D. or Psy.D. Psychologist or Physician for a Peer Review. Peer Reviewers review the SAR and all information submitted with it when making medical necessity determinations. Additionally the Peer Reviewer may contact you to obtain additional information or to better understand the information submitted.

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

If Vaya issues a medical necessity denial without having conducted a peer-to-peer discussion, you may request one within 3 business days of the denial notice. This will ordinarily be with the clinical Peer Reviewer that made the initial decision but if that individual is not available, another equivalent Peer Reviewer will be made available to talk with you. This discussion is not an appeal of the adverse benefit determination but, rather, an opportunity to discuss the decision and the reasons that Vaya could not approve the request. However, if based on the peer-to-peer discussion, the Peer Reviewer determines that a different decision should have been made, he or she may change the initial decision.

How much time does Vaya have to review the SAR?

- Routine Reviews: We will issue a decision within 14 days after we receive a complete SAR. We can extend the deadline up to 14 additional days under certain circumstances, but this is rare.
- Expedited Reviews: You can request an expedited review of a SAR if you believe that adherence to the standard timeframe could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function. If we agree that it is necessary for the request to be expedited, we will complete the expedited review within 72 hours of the request and notify you and/or the member of our decision by phone. We will send a written decision no more than three (3) days after that. If we don't agree that expedited review is necessary, we will notify you and the member of our decision, and process it within the 14 day timeframe. Denial of expedited review cannot be appealed, but you or the member can file a grievance if you disagree with our decision.
- Inpatient Hospitalization and Facility Based Crisis Reviews: We will issue a decision within 72 hours of the initial request. If we receive a request to extend a current course of treatment more than 24 hours before the end of the current authorization, we will make every effort to issue a decision within 24 hours.
- Note that the above timeframes apply regardless of whether the request is for a prospective (i.e. the service is not currently authorized for the member), concurrent (i.e. the service is currently authorized for the member), or retrospective (i.e. the service was already delivered and the provider is seeking authorization to ensure reimbursement) authorization.

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

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

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

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

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

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

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

Decision Notices: Our review of the SAR may result in a full approval, partial approval, or a full administrative or clinical denial. If we issue a partial approval or denial of a SAR, the member will receive a written notice that includes appeal rights and a form to request reconsideration. All written notices are sent via certified mail to the address on file in our system. If a member moves and fails to notify you or their county DSS, this will make it harder for them to receive the notice and file a timely appeal. Please help us make sure that members understand they need to keep their address current with DSS and accept certified mail from Vaya. The effective date of the decision is the date the notice is mailed, except that if a service is terminated or reduced before the current authorization expires, the effective date of the change will be no sooner than 10 days after the date the notice is mailed. Please note that if you request services in excess of a Medicaid policy or Waiver limit for an adult member, we will not provide appeal rights for any portion of services requested over the limit for adult members.

Reconsideration and Appeal Process: As a Network Provider, it is your responsibility to understand and help members with the appeal process. However, you cannot file an appeal on behalf of a member without their written, signed permission. Vaya does not engage in retaliation of any kind against a member, Network Provider, family member or other person who requests a reconsideration, appeal or expedited review. More detailed information about the appeal process is included in the Handbook provided to all members and available on our website, but we included an overview of the appeal process below for your reference. It is very important for members to follow exactly all procedures and timelines outlined in the notice. Members must go through the Vaya reconsideration process before filing a Medicaid appeal with the Office of Administrative Hearings (OAH) or non-Medicaid appeal with DMH/DD/SAS.

The first step is to request a reconsideration review of the Vaya decision. Signed requests for reconsideration must be received by Vaya within 30 days of the notice (for Medicaid services) or 15 working days of the notice (for non-Medicaid services), as follows:

- By fax at 1-877-260-6517
- By mail to Vaya Health, Attn: Appeals Coordinator, P.O. Box 247, Waynesville, NC 28786
- By email to appeals@VayaHealth.com
- In person at any of the offices listed on page 9 of this Manual.
- By phone at 1-800-893-6246, ext. 1400. If a request is made orally, we still need to receive a signed request for reconsideration within 30 days of the date of the notice.
- For assistance, please call the Clinical Support team at 1-800-893-6246, ext. 1400.

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

For Medicaid appeals, we will issue a written decision within 30 days of receipt of a timely request. For non-Medicaid appeals, we will issue a decision within 7 business days of receipt of a timely request. The reconsideration can be expedited if you believe that adherence to the standard timeframe could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function. If we agree that it is necessary for the request to be expedited, we will complete the expedited review within 72 hours of the request and notify you and/or the member of our decision by phone. We will send a written decision no more than three (3) days after that. If we don't agree that expedited review is necessary, we will notify you and the member of our decision, and process it within the applicable appeal timeframe. Denial of expedited review cannot be appealed, but you can file a grievance if you disagree with our decision.

If a member disagrees with our decision, he or she can either: (1) for Medicaid services, file an appeal with OAH within 30 days of the date of the Vaya reconsideration decision notice; or (2) for non-Medicaid services, file an

appeal with DMH/DD/SAS within 11 calendar days of the Vaya appeal decision letter date. Instructions and an appeal form are included with the decision notice. There is no "maintenance of service" under Medicaid managed care or for non-Medicaid services. However, benefits will continue during the appeal through the end of the original authorization period if the member requests continuation of benefits within 10 days of the decision. If a member decides to appeal a Vaya decision and the decision is upheld, Vaya has the right to recover from the member, spouse or parent (if under 18) the cost of services furnished during the reconsideration and appeal process.

Second Opinion: Medicaid beneficiaries have the right to a second opinion if the person does not agree with the diagnosis, treatment, or the medication prescribed. Members are informed of this right in the Handbook sent to them when the individual is enrolled. If a second opinion is requested, you must refer the Member to Vaya's Clinical Operations Department.

Vaya Clinical Plan and Clinical Practice Guidelines: The Clinical Plan defines the philosophical approach and creates the foundation for all of the "clinical operations" of Vaya including Customer Services, Utilization Management, Care Coordination and Network Development. The Clinical Plan is a living document that is reviewed and updated by the Chief Medical Officer with input from the Executive Leadership Team, Clinical Advisory Committee and the CFAC. The goals of the Clinical Plan are to:

- Develop a more comprehensive continuum of care by developing and training a highly qualified and comprehensive Network of Providers;
- Encourage the development and provision of services based on cultural competence, recovery, self-determination, system of care principles and practices, and clinical evidence that have been demonstrated to lead to desired member outcomes;
- Apply the principles of cultural competence and person-centered care to ensure equitable access to, engagement with, and benefit from services for all persons served;
- Ensure timely access to care and service engagement consistent with Vaya and DHHS performance standards;
- Involve members and families in ways that ensure their ownership and satisfaction, and which engender a feeling of shared responsibility for services provided;
- Develop a sense of community ownership that comes from communication, collaboration and a commitment to people of the local communities, including providers; and
- Use data that can be translated into knowledge in order to demonstrate accountability, efficiency, need, quality, outcomes, and awareness of cultural and ethnic variations and to identify areas for change and improvement.

The Clinical Plan also includes a list of the Evidence Based Practices (EBPs) that Vaya endorses for delivery of services to our members. EBPs are an important tool for Network Providers because they describe best practices in various areas of treatment, help improve outcomes and update community practice models. You must be familiar with EBPs and best practices for the services you deliver, and incorporate them into service delivery to the best of your ability.

We adopted or endorsed specific Clinical Practice Guidelines for the treatment of certain conditions and disorders. These Guidelines are developed by national organizations such as the American Psychiatric Association (APA), the American Academy of Child Psychiatrists (AACAP), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Veterans Administration (VA), the Center for Child and Family Health, the British National Institute for Health and Clinical Excellence, the Agency for Healthcare Research and Quality (AHRQ), the National Institute of Mental Health (NIMH), the National Center on Birth Defects and Developmental Disabilities, and other organizations. The Guidelines identify **required** standards for delivery of care and are based on valid and reliable clinical evidence, peer-reviewed studies, and consensus from wide surveys of expert opinions, including actively practicing physicians and other providers with current knowledge relevant to clinical decision making. **We use these Guidelines in making decisions about requests for authorization.** You and your staff must be familiar with them as they apply to the conditions and diagnoses you treat. Guidelines are available at: http://vayahealth.com/providers/managing-care/coverage-information-2/.

Section 7: Member Rights and Empowerment

The protection and promotion of member rights and empowerment is a crucial component of our service delivery system. Vaya Network Providers must respect member rights at all times, provide members with continuing education regarding their rights and support members in fully exercising their rights.

Human Values

Vaya's management of services is based on a set of human values. These values were embedded in the vision of the North Carolina State Plan, called "Blueprint for Change," effective November 30, 2001, which stated that individuals with MH/IDD/SUD service needs should have:

- A meaningful say in the design and planning of the service system
- Information about services and how to access them
- Easy, immediate access to appropriate services
- Services to prevent and resolve crises
- Satisfaction with the quality and quantity of services
- The opportunity to voice complaints
- An orderly, fair and timely system of arbitration and resolution
- Educational and employment opportunities
- Safe and humane living conditions in communities of their choice
- Reduced involvement with the criminal justice system
- Opportunities to participate in community life and make choices

Member Rights

We believe that individuals have the following rights, which are based on the U.S. and N.C. Constitutions, N.C.G.S. Chapter 122C, Article 3, rules codified at Title 10A, Subchapters 27C, 27D, 27E and 27F of the North Carolina Administrative Code (published by DMH/DD/SAS as APSM 95-2), other applicable federal and state laws, rules and regulations, and the Blueprint for Change described above:

- The right to confidentiality and privacy
- The right to be treated with respect and dignity
- The right to humane care and freedom from mental and physical abuse, neglect, and exploitation
- The right to live as normally as possible while receiving care and treatment
- The right to be free from unwarranted searches or seizures

- The right to be free from unnecessary or excessive medication, which shall not be used for punishment, discipline, or staff convenience, and which shall be administered in accordance with accepted medical standards and only upon the order of a physician or other appropriately licensed practitioner
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- The right to be free from any form of discrimination prohibited by federal and state laws, rules and regulations, whether based on race, color, religion, sex, gender, sexual orientation, ethnic or national origin, age, disability, genetic information, or parental status
- The right to freedom of speech and freedom of religious expression
- The right to exercise the same civil rights as any other citizen, including the right to vote, marry, divorce, procreate and raise children, make a will, sign a contract, sue others who wronged them, and buy, sell, and own property, unless the exercise of such rights are precluded by an unrevoked adjudication of incompetency (adults only)
- The right to be free from the threat of unwarranted suspension or expulsion from treatment
- The right to consent to or refuse treatment, except in a medical emergency or an involuntary commitment
- The right to receive treatment in the most natural, age-appropriate and least restrictive environment possible
- The right to participate with treating providers in making health care decisions
- The right to participate in the development and periodic review of a written person-centered treatment or habilitation plan that builds on individual needs, strengths and preferences
- The right to an individualized treatment or habilitation plan that is implemented within thirty (30) days of admission to any inpatient or residential facility
- The right to ask questions of Vaya or treating providers at any point in the process and receive accurate information
- The right to participate in a candid discussion with treatment providers about medically necessary treatment options and alternatives for the relevant diagnosis or condition, regardless of benefit coverage limitation
- The right to be informed in advance of the benefits or risks of treatment choices, and to a second opinion at no cost
- The right to decide among relevant treatment options and express preferences about future treatment decisions regardless of benefit coverage limitation
- The right to be informed of the cost of services at the first visit, or during scheduling of the first appointment
- The right for their health information to be kept secure and confidential by Vaya and treating provider(s) in accordance with federal and state laws, rules and regulations
- The right to request and receive a copy of his or her medical record, subject to therapeutic privilege, and to request that his or her medical record be amended or corrected
- The right to voice complaint(s) or file a grievance about Vaya or the care and treatment received from Network Providers

- The right to receive written notification from Vaya about adverse decisions on requests for prior authorization
- The right to file an appeal with Vaya of the denial, reduction, suspension, or termination of a service, and to request a hearing with OAH (Medicaid services) or DMH/DD/SAS (non-Medicaid services) if the member disagrees with Vaya's final decision
- The right to receive interpretation and translation services and other reasonable accommodations as needed for accessibility, free of charge
- The right to a current listing of Network Providers and access to a choice of providers from within the Closed Network to the extent possible or required by law
- The right to receive information about Vaya, its services, its providers/practitioners and member rights and responsibilities presented in a manner appropriate to the member's ability to understand

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

Grievances, Complaints and Concerns

All Network Providers are required to implement and maintain an internal grievance process to address any grievances, complaints or concerns of the member or member's family related to services provided. This process must be in writing, well-publicized, and communicated to all members upon admission to treatment and upon request from any member. Any unresolved grievances, complaints or concerns should be referred to the Grievance Team at one of the contacts listed below. Vaya Health Plan members can file a grievance with Vaya about any matter other than authorization decisions, either verbally or in writing. You must publicize the process for contacting Vaya to report a grievance, complaint, concern, or potential rights violation:

- Telephone – Call the Customer Services Line at 1-888-757-5726
- Mail – Vaya Health, Attn: Complaints and Grievances, 1207 East Street, Waynesville, NC 28786-3438.
- Email – Grievances@VayaHealth.com

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

- Provider or Vaya staff not keeping an appointment or being disrespectful
- Quality of care or access to services
- Failure to receive services identified in EOB
- Quality of a Network Provider's office or residential site
- Health, safety and welfare issues

- Confidentiality, Privacy and/or Security
- Provider non-compliance with billing or documentation
- Potential fraud, waste or abuse
- Concerns about Vaya's functions, management, activities, or employees

If we receive a grievance about a Network Provider, our first step is usually to call you, get more information, and try to resolve the issue, unless the grievance involves an allegation of fraud, in which case the SIU will be notified, or the grievance involves serious health and safety issues, in which case we will notify our Chief Medical Officer and take immediate action, if needed. You must keep documentation on all grievances received including date received, points of grievances, and resolution information, and must cooperate with grievance inquiries from Vaya. Network Providers are required to respond to Grievance Team members within 10 working days of a request for information. If you do not respond within this timeframe, a decision regarding the grievance will be made without your input and you may be reported to the Vaya Contract Performance Team for follow-up and potential sanction. Based on the nature of grievances we receive, Vaya may also choose to investigate a Network Provider in order to determine the validity of the grievance, or make a referral to another agency, such as the Division of Health Service Regulation (for licensed facilities). Investigations may be announced or unannounced. More information about those investigations can be found in Section 16 of this Manual.

Vaya makes every effort to resolve member grievance within 30 days. Under federal law, we have up to 90 days to resolve a member grievance. Members receive written notification about the resolution of the grievance but the resolution is final. There is no appeal of a grievance resolution.

Non-Discouragement

Vaya staff and Network Providers are prohibited from discouraging a member from exercising his or her rights, including but not limited to the rights to request services, submit a plan of care the member agrees with, file reconsiderations or appeals, ask for expedited review, lodge complaints or grievances with DHHS or Vaya, or report suspicious billing or potential fraud, waste or abuse. Network Providers are specifically prohibited from discouraging a member from filing grievances or complaints with Vaya. Discouragement includes intentionally providing material misinformation to a member. However, Vaya staff and Network Providers can offer alternative services if appropriate, engage in clinical, treatment or educational discussions with members, explain that a request for services may be denied and suggest alternative services, and may explain the appeal process, including Vaya's right to recover the cost of services furnished during an appeal.

Informed Consent and Advocacy

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

- Advocate for medically necessary care or treatment options.

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

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

Right to Privacy and Security

Vaya Network Providers must ensure the confidentiality, privacy and security of all member health records in accordance with the Health Insurance Portability and Accountability Act of 1996, the HIPAA Privacy Rule, HIPAA Security Rule, 42 C.F.R. Part 2, N.C.G.S. 122C, Article 3 and other federal and state laws, rules and regulations. You must also ensure that all employees and contractors maintain the confidentiality of persons receiving services and other information received in the course of providing services. This means that Network Providers and their employees and contractors must not discuss, transmit or narrate in any form any member information of a personal nature, medical or otherwise, except as authorized in writing by the member/ LRP, or as permitted by applicable federal and state confidentiality laws, rules and regulations. It is your responsibility to know what information can be disclosed, to whom, and under what circumstances.

All electronic communications to or from members, or that contains protected health or other sensitive information about members, must be sent via a secure electronic mail system such as Zixmail. Please be aware that the HIPAA Privacy Rule requires all health care providers to develop and distribute a Notice of Privacy Practices that provides a clear, user friendly explanation of individuals' rights with respect to their health information and the privacy practices of the health care provider. More information and model notices are available at http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html. We may ask to see a copy of your Notice at an on-site review. Vaya's Notice of Privacy Practices is available on our website.

Rights of Minors

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

- Venereal (sexually transmitted) diseases

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

24-Hour Facilities

Network Providers who operate 24-hour treatment facilities must provide the member with a document that explains the specific rules for that facility, including rules that cover hygiene, grooming, living environment, personal funds and storage and protection of clothing and possessions. 24-hour facility providers must explain and provide a copy of these rules to individuals within 72 hours of admission. Please refer to Subchapter 27F of the 10A North Carolina Administrative Code, Section .0100 through .105 for more information about this requirement.

Guardianship

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

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

- N.C.G.S. § 35A-1201(5) states that "Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him." This is the public policy of North Carolina. **This means that you must do your best to ensure that persons you are serving who are deemed incompetent are included to the fullest extent possible in treatment team meetings and other venues where decisions about his or her care are made.**

- N.C.G.S. § 35A-1213(g) states that an employee of a treatment facility may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works. This means that

employees of psychiatric residential treatment facilities, group homes, Alternative Family Living homes, Family Care Homes, Adult Care Homes, halfway houses, and other community-based residential facilities licensed by DHSR cannot serve as the guardian for someone who resides at or is receiving inpatient treatment from the facility.

- N.C.G.S. § 35A-1213(f) states that an individual who contracts with, or is employed by an entity that contracts with, an LME/MCO for the delivery of MH/IDD/SUD services may not serve as a guardian for a ward for whom the individual or entity is providing these services. **In general, this means that Vaya Network Providers cannot serve as guardians for Vaya Health Plan members being served by the provider, practitioner or staff member.** There are some limited exceptions:

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

Firearms and Concealed Carry Permits

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

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

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

Restrictive Intervention

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

Client Rights Committee

Agencies contracted for participation in the Vaya Closed Network are required to establish and maintain a Client Rights Committee (also called a Human Rights Committee) in accordance with N.C.G.S. § 122C-164 and 10A NCAC 27G .0504. The Client Rights Committee must establish a process for the reporting of restrictive interventions used by the agency, including seclusion, restraint and isolation time out, as well as a review procedure for member grievances, alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation; concerns regarding the use of restrictive interventions; and failure to provide needed services. Network Providers are required to submit the minutes of their Client Rights Committee meetings to Vaya on a quarterly basis. Prior to submission, you must de-identify any information that is not in relation to Vaya Health Plan members. The Vaya Human Rights Committee is responsible for the monitoring and oversight of Agency Client Rights Committee functions. The HRC receives routine reporting from Vaya staff on the use of restrictive interventions, rights violations and incidents of abuse, neglect and exploitation within the Vaya Closed Provider Network.

Advance Directive for Mental Health Treatment

All states permit some form of legal advance directive for healthcare. Advance directives allow individuals to make decisions about end-of-life care and plan ahead with regard to health treatment, including psychiatric treatment. They are sometimes referred to as "living wills." In 1997, North Carolina developed a statutory process and specific form that can be used for individuals to create an advanced directive for mental health treatment, known as the Psychiatric Advanced Directive or PAD. The PAD enables individuals to plan ahead for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. **You are responsible for educating members about the ability to create advance directives and assisting members who express the desire to create a PAD.** If you are assisting a member in completing a PAD, plan on several meetings to thoroughly think about crisis symptoms, medications, facility preferences, emergency contacts, and preferences for staff interactions, visitation permission, and other instructions. Below are some helpful tips and information:

- The statutory form can be found at N.C.G.S. § 122C-77.
- The PAD form was designed by Duke University. The form and other information are available electronically at http://pad.duhs.duke.edu/.
- The member must sign the PAD in the presence of two (2) qualified witnesses. The signatures must be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a resident, the member's spouse or someone related to the member.
- The PAD becomes effective upon its proper execution and remains valid unless revoked.
- The PAD is not designed for people who may be experiencing mental health problems associated with aging, such as Alzheimer's or dementia.
- A PAD can include a person's wishes about medications, electro-convulsive therapy (ECT), admission to a hospital, restraints, and whom to notify in case of hospitalization.
- The PAD may include instructions about paying rent or feeding pets while the member is in the hospital.
- The member can include the name of their treating psychiatrist or clinician with instructions for the ED to call him or her and follow their instructions if the member is unable to speak for him or herself or is confused.

Upon being presented with a valid PAD, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the PAD when the person is determined to be incapable, unless compliance is not consistent with generally accepted or best practice standards of treatment to benefit the member [see N.C.G.S. § 122C-74(g)], availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a 24 hour facility and undergoing treatment as provided by law. If the physician or provider is unwilling to comply with all or part of the advance directive, he or she must notify the member and record the reason for noncompliance in the patient's medical record.

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

Section 8: After-Hours Requirements and Crisis Planning/Response

Comprehensive Crisis Plan Development

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

Who is required to have a Comprehensive Crisis Plan? Network Providers MUST ensure that ALL individuals with Person-Centered Plans also have completed Comprehensive Crisis Prevention and Intervention Plans. In addition, all members who are at significant risk of crisis events - including those receiving only basic benefit services, should have a CCP in place. This would include persons who received inpatient psychiatric or substance use treatment, been arrested, attempted suicide, or used crisis services within the past year. Crisis services would include Mobile Crisis Management (MCM) team, Facility Based Crisis (FBC), non-hospital detoxification, walk-in crisis, NC START, or use of a hospital ED for reasons related to psychiatric illness or substance use.

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

- The individual has been referred to or discharged from NCSTART; or
- The individual has been referred to or discharged from a State Developmental Center or ICF-IID; or
- The individual has received two unplanned restraints in one quarter.

How and when is the CCP updated and shared? Individuals receiving services must be provided with a copy of the plan and all pertinent crisis contact/ after hours numbers to utilize in an emergency. CCPs are "live documents," and must be reviewed and updated as needed. Plans are required to be updated annually and whenever a member's medications or natural supports change or other significant change occurs that impacts crisis planning. CCPs should be reviewed after every crisis event (such as utilizing MCM, an Emergency Department (ED) stay, and/or a psychiatric hospitalization) and updated as needed. Network Providers must upload all completed CCPs to the member's AlphaMCS profile labeled with member's initials_CCP_Date (YYMMDD), for example: JD_CCP_20151001, and identified as Document Type "Crisis Plan." This enables it to be

easily retrieved and shared in a crisis. Where permitted under applicable privacy laws, Vaya may share a member's CCP with an ED or a Mobile Crisis provider in order to help alleviate or respond to a crisis situation. For this reason, it is critical that CCPs be uploaded as soon as possible following completion or any updates to the plan.

After Hours Coverage Requirements

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

Providers of Basic Benefit Services (e.g., Outpatient Clinics or Licensed Independent Practitioners) and other services without first responder requirements must have capacity to provide 24/7 telephonic crisis intervention/response to members they serve.

- Basic Benefit Providers must offer an answering service or voicemail with the provider's after hours contact number – the message must not direct members to 911 or the emergency department (ED) unless their emergency is life threatening. All members must be provided with the mobile/ pager/ answering service number of the clinician who is on call. If the provider is using an answering service, the provider must return the call to the member within 15 minutes. After hours recordings and voicemail messages must include the applicable emergency contact information.
- Crisis Plans must be developed with all members and include the provider's day time and after hours/ emergency contact information along with helpful strategies to mitigate crisis. Members should have copies of the crisis plan and pertinent contact/crisis afterhours numbers for providers.
- Basic Benefit Providers responding to members in crisis must have 24/7 access to Crisis Plans and other information in the member's treatment record to guide crisis intervention.
- Basic Benefit Providers must be able to respond telephonically, but may access Mobile Crisis Services for the member if telephone contact cannot mitigate the crisis.

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

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

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

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

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

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

Other BHCH Providers may include providers of Day Treatment and Psychosocial Rehabilitation as well as 24 hour residential treatment providers. Outpatient therapists assume clinical home functions in the event that outpatient services are being delivered and none of the above services are a part of the member's Person-Centered Plan (PCP). If the individual is not connected with another provider upon discharge from a BHCH, the Behavioral Health Clinical Home will retain emergency response duties for 60 days post discharge.

Relationship between First Responders and Mobile Crisis: Vaya contracts with three Comprehensive Care Center providers to deliver Mobile Crisis Management (MCM) and other crisis services throughout our catchment area. **Network Providers with first responder responsibilities, including the CCC providers, should not use MCM as the first responder, even if it is their own MCM team.** This does not meet the intent of a first responder. The first responder function should be separate. MCM, which is a higher level service, should only be utilized once the First Responder attempted telephonic intervention or face to face assessment **and** implementation of the CCP without success. However, note that ACTT providers have more intensive crisis responsibilities under DMA

Clinical Coverage Policy No. 8A-1, and should only call MCM if all other alternatives are exhausted.

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

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

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

Direct Care Providers of State Funded I/DD Services such as Individual Habilitation/Personal Assistance must also develop appropriate crisis plans for persons they serve. Members and their support persons must be trained in implementing the plan, and all individuals/ providers included in the crisis plan must be know and understand their role in crisis response.

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

Frequently Asked Questions

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

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

When should a Mobile Crisis Management (MCM) team be called to handle a member who is in crisis? Vaya will contact and refer to MCM if the first responder is not accessible, to assure the member receives timely engagement in crisis services. Providers may consult and refer directly to MCM after their first responder intervention failed to safely manage the crisis and /or divert from the hospital. Providers are not required to go through Vaya Customer Services to make a referral to MCM.

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

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

The Crisis Continuum

There is a strong continuum of services available to help support and stabilize members in crisis. As a Network Provider, you must be aware of the resources available, how to access Crisis Response services, implement them to fit the nature of the member's crisis, and understand your role and responsibilities within the crisis continuum. Vaya contracts with three MCM teams to cover the entire 23 county catchment area. There are walk-in centers in each county, operated by Vaya's contracted Comprehensive Care Centers, where members can go to receive same-day assessment and treatment. There are also Facility Based Crisis (FBC) centers in three counties that serve the region. As discussed above, basic benefit providers may utilize MCM for face to face assessment and intervention if the provider's phone response does not reduce the crisis. First responders/ enhanced services providers must assess members in crisis face to face and consider all other alternatives to hospitalization such as use of family or community resources, initiation of medication or medication adjustments, safety planning, arranging follow-up, etc., prior to contacting MCM or the Vaya Call Center. Interventions should focus on the least restrictive options, starting with the CCC walk-in centers, MCM, FBC or detoxification facility, before considering inpatient hospitalization. If the first responder's assessment is that the member needs inpatient level of care, some hospitals will consider direct referrals from the community provider. All alternatives should be attempted prior to going to the ED. Options become more limited when a person enters the ED. A list of regional walk in facilities, MCM providers and FBC centers for detox or crisis stabilization are available on our website at: http://vayahealth.com/community/comprehensive-care-centers/.

Housing and Employment

One of the primary barriers that prevents members from remaining stable and avoiding a crisis is lack of housing and/or employment. Vaya has a Housing & Employment Team that works to address these critical social determinants of health, provides information on available housing options to members, families, community stakeholders and providers, administers the Housing and Urban Development (HUD) Shelter Plus Care and other Vaya housing programs and works to increase housing resources through partnerships with affordable housing providers. Employment activities include working with employment service providers to increase the quality of services, providing information on available supported employment options to members, families, community stakeholders and providers, and working directly with members when paid employment supports are not successful. Network Providers are required to collaborate with Vaya in these efforts and must:

- Participate in or refer landlords and other stakeholders to Vaya's housing initiatives.
- Assist members as needed to remain stably housed.
- Participate in Vaya's internal and/or external trainings to implement evidence-based Supported Employment (SE) within your organization as applicable.
    - The primary outcome of SE is competitive employment in an integrated setting (50% or more non-disabled) consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and involving informed choice.
    - To establish a valued sense of integrity and purpose within SE/Long Term Vocational

Support (LTVS), Network Providers must gather/ collect and report requested data to Vaya for use in determining needs and barriers to employment within our catchment area.

- For those providers who are contracted to provide SE or ACTT services, you must provide SE program data that includes: Member development/phase of service (i.e. job development, creation of small business/micro-enterprise, placement, or long term vocational support) and outcomes, including the number of individuals who obtained jobs, the member's start date, hours worked, wages and benefits, and pertinent employer information. Reporting must be submitted electronically on a quarterly basis to the following email address: SupportedEmployment@VayaHealth.com
- For those providers who are contracted to provide State Funded Residential Services (SFRS):
    - Maintain a current list of those members for whom the agency is receiving SFRS funding
    - Submit Unused Bed Day Census reports monthly
    - Notify Vaya of vacancies within one day
    - Follow guidelines for the SFRS Referral Process
- For providers who signed a Memorandum of Agreement to make referrals into the Shelter Plus Care/Permanent Supportive Housing (SPC/PSH) Program:
    - Provide ongoing services to SPC/PSH referred participants as needed and provide monthly reports of those services
    - Communicate regularly with the Housing Coordinator when changes occur, such as the participant's stability, income, household composition, etc.

Community Collaboration

As a Network Provider, you must cooperate with our Crisis Prevention and Community Collaboration efforts. Minimum requirements include the following:

- Actively participate in efforts to develop prevention, education, and outreach programs.
- Assist in the development of educational material and brochures on mental illness, intellectual/developmental disabilities, and substance use disorders to reduce stigma and educate the community about the needs of people you serve.
- Provide education to stakeholders and members on services available within Vaya's Closed Provider Network, appeals and grievances, and advance directives.
- Cooperate with and/or actively participate in Vaya in In-Reach and TCLI team activities, as applicable.
- Participate in local Crisis/Emergency Department Initiative (CEDI) Committee activities.
- Make referrals to GAMHST for caregivers of older adults needing additional education, support, and resource information as needed.

Section 9: Care Coordination

Vaya provides integrated, whole person care coordination through community based MH/SUD and I/DD teams. The Care Coordination (CC) department also includes Supports Intensity Scale (SIS®) Assessors for Innovations Waiver eligible and potentially-eligible participants, the Geriatric and Adult Mental Health Specialty Team, as well as liaisons based directly in state facilities and contracted hospitals. In accordance with 42 CFR § 438.208(b), Vaya performs coordination of care for all Medicaid enrollees, including those dually eligible for Medicare and Medicaid. However, **not all members will qualify for an assigned care coordinator to perform care coordination for the member.** Instead, an assigned care coordinator is provided to members based on criteria set by DMA and DMH/DD/SAS. CC functions and activities include the identification, assessment, coordination, monitoring and linkage to medically necessary behavioral health treatment/ habilitative services, community supports, medical, dental health treatment, primary care and specialists. These activities are dependent on the member's individual needs and funding source.

Admission Criteria and Covered Populations

Under the DMA Waiver Contract, we provide an assigned care coordinator for the following Medicaid populations:

- Members who fall under Special Healthcare Needs designation as defined below;
- Members engaged with Community Care of North Carolina (CCNC) networks;
- Innovations Waiver participants;
- Members admitting and discharging from hospital and institutional settings receiving a behavioral health inpatient service;
- Members designated as High Risk/High Cost as defined below;
- Members who are on Outpatient Commitment;
- Individuals who transitioned into the community through the Transitions to Community Living initiative;
- Youth (under age 18) being admitted to or discharged from mental health or substance use residential level III or IV group homes or a Psychiatric Residential Treatment Facility (PRTF); and
- Individuals who currently reside in an Intermediate Care Facility for Individuals with I/DD (ICF-IID) who could be successfully transitioned to a community setting.

Medicaid members who do not fall into one of the categories listed above are not eligible for a Vaya-assigned care coordinator. Please note that lack of housing or diagnosis of Traumatic Brain Injury by itself DOES NOT qualify a person for an assigned care coordinator regardless of disability group or funding source. Under N.C.G.S. Chapter 122C and our DMH/DD/SAS contract, we also provide an assigned care coordinator for the following populations enrolled in our Non-Medicaid Health Plan:

- Members without a Behavioral Health Clinical Home being discharged from an inpatient setting;

- Members designated as High Risk/High Cost as defined below; and
- Members who are on Outpatient Commitment.

Special Healthcare Needs Populations

DMA defines populations with special healthcare needs as the following:

Intellectual and/or Developmental Disabilities

- Individuals who are functionally eligible for, but not enrolled in, the Innovations Waiver and not living in an ICF-IID; or
- Individuals with an I/DD diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Public Safety (DPS), Division of Juvenile Justice (DJJ) for whom Vaya received notification of discharge.
- Although individuals in ICF-IIDs are not eligible for an assigned care coordinator, Vaya staff participate in the annual Plan of Care meetings for members who reside in ICF-IIDs and are appropriate for community placement.

Child Mental Health

- Children under age 18 with a current CALOCUS© level of VI and a diagnosis within the following diagnostic ranges:

	ICD-9	**ICD-10**
➢	293.0	F05
➢	293.81	F06.2
➢	293.82	F06.0
➢	293.83	F06.30
➢	293.84	F06.4
➢	293.89	F06.1
➢	294.10	F04
➢	294.11	F02.81
➢	294.8	F06.0
➢	294.9	F06.8
➢	295.40	F20.81
➢	295.70	F25.9
➢	295.90	F20.9
➢	296.20	F32.9
➢	296.21	F32.0
➢	296.22	F32.1
➢	296.23	F32.2
➢	296.24	F32.3
➢	296.25	F32.4
➢	296.26	F32.5
➢	296.30	F33.9

	ICD-9	ICD-10
➢	296.31	F33.0
➢	296.32	F33.1
➢	296.33	F33.2
➢	296.34	F33.3
➢	296.35	F33.41
➢	296.36	F33.42
➢	296.40	F31.10
➢	296.41	F31.11
➢	296.42	F31.12
➢	296.43	F31.13
➢	296.44	F31.2
➢	296.45	F31.73
➢	296.46	F31.74
➢	296.50	F31.30
➢	296.51	F31.31
➢	296.52	F31.32
➢	296.53	F31.4
➢	296.54	F31.5
➢	296.55	F31.75
➢	296.56	F31.76
➢	296.7	F31.9
➢	296.80	F31.9
➢	296.89	F31.81
➢	296.99	F34.8
➢	297.1	F22
➢	298.8	F23
➢	298.9	F29
➢	300.00	F41.9
➢	300.01	F41.0
➢	300.02	F41.1
➢	300.09	F41.8
➢	300.11	F44.4, F44.6
➢	300.12	F44.0
➢	300.13	F44.1
➢	300.14	F44.81
➢	300.15	F44.9
➢	300.19	F68.8
➢	300.22	F40.02
➢	300.23	F40.10
➢	300.29	F40.8, F40.218, F40.240, F40.241
➢	300.3	F42
➢	300.4	F34.1
➢	300.6	F48.1
➢	300.7	F45.21, F45.22
➢	300.82	F45.1, F45.9
➢	300.89	F45.8, F48.8

	ICD-9	ICD-10
➢	300.9	F48.9, F99
➢	300.99	Not in DSM-5
➢	302.2	F56.6
➢	302.3	F65.1
➢	302.4	F65.2
➢	302.6	F64.2
➢	302.1	Not in DSM-5
➢	302.70	R37
➢	302.71	F52.0
➢	302.72	F52.21, F52.8
➢	302.73	F52.31
➢	302.74	F52.32
➢	302.75	F52.4
➢	302.76	F52.6
➢	302.79	F52.1, F52.8
➢	302.81	F65.0
➢	302.82	F65.3
➢	302.83	F65.51
➢	302.84	F65.52
➢	302.85	F64.1
➢	302.89	F65.81, F65.89, F66
➢	302.9	F65.9
➢	307.0	F98.5
➢	307.1	F50.00
➢	307.20	F95.9
➢	307.21	F95.0
➢	307.22	F95.1
➢	307.23	F95.2
➢	307.3	F98.4
➢	307.45	F51.8
➢	307.46	F51.3
➢	307.47	F51.8
➢	307.50	F50.9
➢	307.51	F50.2
➢	307.52	F98.3
➢	307.53	F98.21
➢	307.59	F50.8, F98.29
➢	307.6	F98.0
➢	307.7	F98.1
➢	307.9	F63.3, R45.1
➢	308.3	F43.0
➢	309.81	F43.10, F43.12
➢	311	F32.9
➢	312.23	F91.2
➢	312.31	F63.0
➢	312.32	F63.2

	ICD-9	ICD-10
➢	312.33	F63.1
➢	312.34	F63.81
➢	312.39	F63.3, F63.89
➢	312.81	F91.1
➢	312.82	F91.2
➢	312.89	F91.8
➢	312.9	F91.9
➢	313.81	F91.3
➢	313.89	F94.2, F94.1, F93.8, F98.8
➢	995.51	T74.32XA, T76.32XA
➢	995.52	T74.02XA, T76.02XA
➢	995.53	T74.22XA, T76.22XA
➢	995.54	T74.12XA, T76.12XA
➢	V61.21	Z69.010; or

- Children with an MH or SUD diagnosis who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center or Youth Detention Center) operated by DOC or DJJ, inpatient hospital setting, Cumberland Hospital, PRTF or therapeutic group home for whom Vaya received notification of discharge. This target group may also include children who are at imminent risk for entering these levels of care. CC partners with DSS and DJJ to identify and engage high risk children and their families in services to reduce out of home placements and connect to appropriate services.

<u>Adult Mental Health</u>

- Adults ages 18 and over with a current LOCUS© level of VI and a diagnosis within the following diagnostic ranges:

	ICD-9	ICD-10
➢	295.40	F20.81
➢	295.70	F25.9
➢	295.90	F20.9
➢	296.20	F32.9
➢	296.21	F32.0
➢	296.22	F32.1
➢	296.23	F32.2
➢	296.24	F32.3
➢	296.25	F32.4
➢	296.26	F32.5
➢	296.30	F33.9
➢	296.31	F33.0
➢	296.32	F33.1
➢	296.33	F33.2
➢	296.34	F33.3

➢	296.35	F33.41
➢	296.36	F33.42
➢	296.40	F31.10
	ICD-9	**ICD-10**
➢	296.41	F31.11
➢	296.42	F31.12
➢	296.43	F31.13
➢	296.44	F31.2
➢	296.45	F31.73
➢	296.46	F31.74
➢	296.50	F31.30
➢	296.51	F31.31
➢	296.52	F31.32
➢	296.53	F31.4
➢	296.54	F31.5
➢	296.55	F31.75
➢	296.56	F31.76
➢	296.7	F31.9
➢	296.80	F31.9
➢	296.89	F31.81
➢	296.99	F34.8
➢	298.9	F29
➢	309.81	F43.10, F43.12

- Adults with more complex diagnostic patterns including Substance Dependent or co-occurring I/DD are also eligible for care coordination, as set forth below.

Substance Dependent: Individuals are considered substance dependent with a substance dependence diagnosis and current ASAM PPC Level of 3.7 or II.2-D or higher.

Co-occurring Diagnoses: Individuals with co-occurring diagnoses may be a combination of mental health, substance use and/or I/DD. The following criteria are required to be considered eligible for an assigned care coordinator under the Special Health Care Needs criteria for co-occurring diagnoses:

- Individuals with both a mental health diagnosis and a substance use diagnosis and a current LOCUS©/CALOCUS© of V or higher, or current ASAM PPC Level of 3.5 or higher; or
- Individuals with both a mental health diagnosis and an I/DD diagnosis and current LOCUS©/CALOCUS© of 5 or higher; or
- Individuals with both a substance use diagnosis and an I/DD diagnosis and current ASAM PPC Level of 3.3 or higher.

At-Risk for Crisis Enrollees: Individuals (to the extent not included within one of the above populations):

(1) who do not appear for scheduled appointments and are at risk for inpatient or emergency treatment; or

(2) for whom a crisis service was provided as the first service, in order to facilitate engagement with ongoing care; or

(3) discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility, or Facility-Based Crisis or general hospital unit following admission for a MH/IDD/SUD condition.

Children with Complex Needs: Children with complex needs (to the extent not included within one of the above populations) are Medicaid eligible children ages 5 and under age 21 with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting. The term "at risk" is defined for this purpose as acts or behaviors that present a substantial risk of harm to the child or to others.

Other Medicaid-Only Care Coordination Admission Criteria

Community Care of North Carolina (CCNC): Members who are enrolled with a CCNC network may be eligible for an assigned care coordinator through Vaya. Vaya and CCNC operate under what is called a Four Quadrant model to determine whether CCNC or Vaya is primarily responsible for care coordination for a specific member. Essentially, Vaya is responsible for all individuals enrolled with a CCNC network who experience high MH/IDD/SUD health complexity or risk and low physical health complexity or risk. Vaya and CCNC work together to determine who should be primarily responsible for individuals with high levels of both MH/IDD/SUD and physical health complexity/ risk. The CC department staff complex cases with CCNC and collaborates with them to ensure that members are linked to necessary services. All members assigned to Vaya Care Coordination are required to be referred and linked to both medical homes as well as Behavioral Health Clinical Homes. In situations where members choose to not engage in behavioral health or medical home services, continued attempts will be made to link the member to care for the duration of the CC intervention.

Innovations Waiver Participants: Innovations Waiver slots are allocated by DMA to each LME/MCO. Vaya approves Waiver slot enrollment on a first come, first serve basis. Individuals who are assigned an Innovations slot receive an assigned care coordinator and care coordination services as part of the Waiver. This includes ISP development and monthly health and safety monitoring. Vaya maintains a list of individuals wishing to be considered for participation in the Innovations Waiver, called the Registry of Unmet Needs. If a slot becomes available, CC will notify individuals who meet criteria in order to process the eligibility determination request and begin development of a plan of care.

Care Coordination Admission Criteria

The following categories of individuals are eligible for an assigned care coordinator through Vaya regardless of

funding source (i.e., whether they are enrolled in Medicaid or in Vaya's Non-Medicaid Benefit Plan):

High Risk/ High Cost Members: In accordance with N.C.G.S. § 122C-115.4(f), a high risk individual is someone who was assessed as needing emergent crisis services 3 or more times in the previous 12 months. For purposes of high risk eligibility, "emergent crisis services" means Mobile Crisis Management (MCM) team intervention, FBC admission, or ED primary behavioral health intervention. In accordance with N.C.G.S. § 122C-115.4(f), a high cost individual is someone whose treatment plan is expected to incur costs in the top 20% of all members in a specific disability group (MH, SA or I/DD).

Members Discharged from Inpatient or Crisis Settings: Individuals who are not engaged with a community-based behavioral health provider or do not have a Behavioral Health Clinical Home **and** are being discharged from state facilities, hospital EDs, inpatient psychiatric services, detoxification facilities or FBC centers, are also considered high risk, and may receive care coordination services until such time as they are linked to a behavioral health provider for ongoing follow-up and intervention. Vaya works to ensure that these individuals are seen by a community-based Network Provider within 7 days of discharge. Network Providers must make every effort to ensure that appointments are available for these high risk individuals. If a member fails to show up at a scheduled appointment, Vaya staff will contact them within 5 days to reschedule services.

Outpatient Commitments: Vaya provides care coordination services for all members who are under a valid Outpatient Commitment (OPC) order. This includes maintaining up-to-date records on each member in the catchment area with an OPC order, including the name or names of their treatment provider(s) and documentation of CC contacts to verify the member compliance with the outpatient commitment order. If the assigned care coordinator determines that the member failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the CC must report such failure as required by law. More information about inpatient, substance use and outpatient commitments is included in Section 11 of this Manual.

Referral Process for an Assigned Care Coordinator

If a Network Provider wishes to refer a member for an assigned care coordinator, you must complete the CC Referral form and send it to the Vaya MH/SUD or I/DD CC Manager for the region where the individual resides. The form is available at: http://vayahealth.com/members-caregivers/member-services/care-coordination/. Referrals can also be made through the Customer Services department, by other Vaya staff members, community stakeholders, members and their natural supports. The Referral form must be transmitted through secure email or via fax, mail or hand delivery. Instructions can be found directly on the referral form. The referral request will be reviewed for eligibility for an assigned care coordinator within 5 business days of receipt:

- If eligible, the applicable CC Manager assigns the individual to a care coordinator and contacts the member and/or LRP to initiate services within a reasonable timeframe. Assignments are made based on county of residence and CC caseload diversity. In general, Vaya will not process requests for a change in the assigned care coordinator absent a compelling reason, such as a documented instance of

inappropriate behavior or interaction by the care coordinator. Vaya will not re-assign care coordinators in response to requests based on discriminatory reasons such as race, color, religion, sex, gender, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information, or parental status.

- If not eligible, the CC Manager will electronically notify the requestor of the determination and reason(s) for ineligibility of CC services. **This decision is not an "action" or "adverse benefit determination" that is subject to appeal.** Individuals who are dissatisfied with the decision may file a grievance or complaint or contact the CC Manager to discuss.

Care Coordination Role

Care Coordination staff will be available at times reasonably convenient to the member and their family for telephonic consultation and face to face meetings. This means that we are willing to schedule meetings after hours and on the weekends if necessary to meet the unique needs of the member and his or her family. This does not mean that we will agree to meet at unreasonable times such as late at night or Sunday morning. If the member or natural support's behavior or home environment presents a risk to the health, safety or well-being of the assigned care coordinator, we reserve the right to hold meetings in a neutral location such as the Network Provider's office and/or include a care coordination manager in the meeting. Dangerous home environments include locations where unsecured or illegal weapons, illegal substances or dangerous animals are present. We will not tolerate physical or verbal abuse of our CC staff by members, natural supports, or Network Providers or their staff. This includes but is not limited to profanity, yelling, gross disrespect, inappropriate physical interactions or violations of personal space. In such cases, we reserve the right to immediately terminate the meeting or telephone call and report such behavior to the Network Provider.

If the member has a Behavioral Health Clinical Home and receives services that include certain care coordination or case management activities per the applicable DMA Clinical Coverage Policy, DMH/DD/SAS state services definition or the Network Provider's contract with Vaya, CC staff will ensure that the member's care coordination needs are met via the Network Provider. A failure to provide required care coordination services or cooperate with assigned care coordinators will result in a referral for investigation and may lead to administrative action or sanction, up to and including termination of contract. In cases where there is not an identified Behavioral Health Clinical Home, the assigned care coordinator will provide certain CC activities and functions outlined in Vaya's contracts with DMA and DMH/DD/SAS according to the type of population.

Vaya care coordinators do not make authorization decisions and there is a "firewall" in place at Vaya to ensure that authorization decisions are made independently without inappropriate influence from a care coordinator or other Vaya staff member. For Intellectual and Developmental Disability Care Coordination specifically, the I/DD Care Coordinator will follow internal policy regarding eligibility for Reserved Capacity or Non- Reserved capacity slots for a potentially eligible NC Innovations participant.

Discharge from an Assigned Care Coordinator

A member is discharged from an assigned MH/SUD Care Coordinator when the services are determined to be effective and the member is stable or stabilizing as evidenced by:

- No psychiatric or behavioral health inpatient or crisis admissions or placements within the previous 90 days;
- Did not need MCM or other crisis service within the previous 90 days;
- Is engaged with a BHCH or other community-based behavioral health provider, as evidenced by the fact that the member can identify his or her provider(s), participated in their plan development and attended 4 appointments within the previous 45 days;
- If applicable, all Outpatient Commitment requirements are met; or
- Despite multiple attempts to engage, the member or LRP continues to refuse CC services.

Innovations Waiver participants will not be discharged from the I/DD Care Coordination Team unless their Innovations Waiver slot is terminated. Other members with I/DD who do not meet ICF-IID level of care will be discharged from an assigned care coordinator when:

- The member did not have any psychiatric or behavioral health inpatient or crisis admissions or placements within the previous 90 days;
- The member did not require a crisis service from NC START or MCM team within the previous 90 days;
- The member is engaged with a behavioral health, residential or habilitative service provider or their service needs are being met, as evidenced by the fact that the member/ LRP can identify his or her provider(s), participated in their plan development and attended 4 appointments or received 4 service visits within the previous 45 days
- If applicable, all Outpatient Commitment requirements are met; or
- Despite multiple attempts to engage, the member or LRP continues to refuse CC services.

Geriatric and Adult Mental Health Specialty Team (GAMSHT/GERO Team)

The Gero team is comprised of registered nurses, licensed clinicians, and qualified mental health professionals who provide education and consultation for staff of a variety of community agencies (i.e. senior centers, adult day care programs, Departments of Social Services, Veteran Affairs, home health agencies, faith based organizations, law enforcement) and all levels of long-term care. The team may also assist caregivers of individuals 60 years and older with mental health and/or substance use concerns.

Acute Care Response Team

The Acute Care Response team includes hospital liaisons embedded at local hospitals and state facilities to ensure effective discharge planning of high-need members admitted to 24-hour inpatient facilities by evaluating their needs/level of care and assisting with a smooth transition and adequate linkage to the assigned Vaya care coordinator and providers in the community upon discharge, as well as other acute response care coordinators

who work to reduce or divert inappropriate emergency department (ED) utilization, and help providers, members, families and stakeholders with members experiencing an acute crisis or emergent care need.

Network Provider Care Coordination Responsibilities

As a Network Provider, you must fully cooperate with Vaya's care coordination and integrated care activities, including but not limited to the following:

- Actively participate in interdisciplinary team meetings convened or arranged by the care coordinator and/or include the care coordinator in team meetings convened or arranged by you.
- Provide at least 24 hours prior notice to the care coordinator of the date, time and place of any treatment team or discharge planning meeting involving a member with an assigned care coordinator.
- Provide accurate and timely information to the care coordinator regarding the member's participation in treatment and clinical progress.
- Work with the CC and the Child and Family or Adult planning team in developing an appropriate, whole person plan of care (ISP or PCP), including crisis planning for individuals regardless of disability type. Treatment plans must address mental health, substance use/ addiction, I/DD, medical, dental and specialty needs, evidence of medication reconciliation across all care providers and include a detailed, cross system comprehensive crisis plan using evaluations, assessments and collateral information.
- Develop and implement treatment and/or supports strategies to address assigned areas of responsibility from the PCP or ISP.
- Develop step down and discharge plans within the first month of admission.
- Take the primary role in transitions to other levels of care.
- Notify the assigned care coordinator whenever a member receiving CC services is admitted to an ED/ FBC or inpatient unit.
- Provide accurate information to members and their families regarding clinical coverage policies and levels of care that are typically most effective at treating or supporting a member's treatment or habilitative need and helping a member and his or her family plan for multiple treatment options.
- Timely and accurately completing all appropriate or required level of care/ clinical decision support tools identified in Section 6 of this Manual, including but not limited to the LOCUS©, CALOCUS©, CANS-MH, NC-SNAP, SIS®, and ASAM placement criteria.
- Work with Vaya, PCCM, primary care providers and other Vaya contracted providers regarding a member's medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem solving as well as identification of medical home for persons in need.
- Follow the process for admissions to a State Developmental Center. Any application for a State Developmental Center must be coordinated with the MCO. The member/ family/ LRP or Network Provider/ assigned I/DD Care Coordinator/ Olmstead Care Coordinator must provide the Critical Case Staffing with all information necessary to determine if application to a State Developmental Center should be made for a complete admission packet to be submitted. Assigned I/DD Care Coordinators and

our Olmstead CC will review the application to ensure that all other reasonable lower levels of care were exhausted first. Vaya must provide a letter of support in order for the application to be accepted. For individuals who are accepted into a State Developmental Center, the Olmstead CC will follow the individual through discharge. **State Developmental Centers are not considered long term or lifetime residential placements** and individuals must be reviewed quarterly for discharge consideration. Each member accepted for admission to a State Developmental Center will be accepted only under a Memorandum of Agreement for one year. All individuals will be discharged with the date stated on the MOA.

Section 10: Emergency Services and Hospital Requirements

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

Emergency and Crisis Stabilization Services

Vaya will provide reimbursement for emergency and crisis stabilization services for eligible Medicaid beneficiaries at any time without regard to prior authorization or whether the provider is contracted with Vaya. However, the treatment must fall within the scope of services covered under the 1915(b)/(c) Waiver. In other words, Vaya will not reimburse a provider for cancer treatment based on the member having a behavioral health diagnosis. Medical treatment provided in the ED that is unrelated to behavioral health is the responsibility of DMA. If you are unsure about whether a service should be billed to Vaya or to DMA, please refer to the Mixed Services Payment Protocol attached as Appendix C to this Manual. The Protocol is included in our DMA Waiver Contract and in all contracts between Vaya and hospitals.

Emergency services means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition as defined at 42 CFR § 438.114(a). We do not limit what is considered an emergency medical condition on the basis of lists of diagnoses or symptoms. We consider Facility Based Crisis (FBC) services to fall within this definition. Crisis stabilization or “post-stabilization care” services generally means covered inpatient and outpatient services that are provided in order to maintain the stabilized emergency medical condition. Requests for reimbursement for emergency services must be presented to Vaya within 90 days of treatment or discharge. We will not require you to enter into a contract for reimbursement but we will ask you to complete a billing enrollment form so that we have information required for our financial records**. You may not bill Medicaid members (or otherwise hold them liable for payment) for screening and treatment that was needed to diagnose an emergency medical condition or stabilize the individual.**

If the individual was not enrolled with Vaya at the time of service delivery, Vaya will enroll them as soon as

possible. The date of enrollment will be the date the emergency or post-stabilization care services were provided. Individuals must be enrolled in our system, however, before they can receive additional, non-crisis services.

Emergency Department Admission Notification

If a member of a Vaya Health Plan, or someone who you believe may be eligible for a Vaya Health Plan, presents at an emergency department (ED) or Facility Based Crisis (FBC) in a behavioral health crisis, the facility must inform Vaya of the admission via a daily report to Vaya's Crisis Coordination team and/or by calling the Vaya Customer Services department at **1-800-849-6127**. The hospital ED or facility where the individual is receiving treatment is ultimately responsible for assessment and disposition of individuals in their care. However, Vaya employs crisis staff and hospital liaisons who are available to provide ED and FBC staff with consultation, coordination with the individual's Behavioral Health Clinical Home (BHCH), and education on possible resources for appropriate treatment. If the member is not engaged with a BHCH or other provider and meets criteria for Care Coordination, the Crisis Coordinator will refer to the Care Coordination Department for follow-up by a Care Coordinator.

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

You must notify Vaya whenever a Vaya Health Plan member is discharged from the ED or FBC within 24 hours of discharge. If a member who presented to the ED or FBC with a behavioral health issue is discharged, you must arrange for a follow-up appointment with the individual's BHCH, or if there is no BHCH, with an appropriate outpatient or other behavioral health provider within 5 business days of discharge. Vaya Customer Services staff can assist with arranging the follow-up appointment for members who are not yet connected with services. Please call the 24/7 Access to Care line at **1-800-849-6127** for assistance with appointments.

Inpatient Admission Notification and Authorization of Stay

Vaya generally honors a 72 hour "pass through" for inpatient psychiatric treatment. This means that we do not require prior authorization for the first 72 hours of an inpatient stay. However, we reserve the right at any time to conduct post-payment review to verify the medical necessity of any inpatient stay, and may identify an overpayment if it is determined that inpatient treatment was not medically necessary or delivered in accordance with all requirements of the Controlling Authority listed in your Contract or Out of Network Agreement, including but not limited to DMA Clinical Coverage Policy No. 8B.

Regardless of this 72 hour pass through period, you must notify Vaya within 24 hours of any inpatient admission

of a Vaya Health Plan member in order for us to immediately link the member to a community-based provider or work with the member's existing provider on discharge planning. Effective discharge planning is critical to reduce the cycle of readmission for some of our members with serious and persistent mental illness. **You must notify us of an inpatient admission by calling the Vaya Customer Services department at 1-800-849-6127 within 24 hours of admission.** We reserve the right to deny authorization and reimbursement of the initial 72 hour pass through period if you fail to notify us of the individual's admission within this timeframe.

Certification for continued hospitalization or services include the number of extended days or units or service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services. Requests for continued stay must be submitted electronically via AlphaMCS. The following information must be included in SARs: original admission information including category of disability and diagnostic profile, reasons for requesting continued stay including current risk factors, current medications, name of attending physician, anticipated discharge date and plan that notes step-down services and discharge living arrangement. For members with primary diagnoses of substance use Vaya requires the following: current vital signs, Clinical Institute Withdrawal Assessment for Alcohol (CIWA or CIWA-Ar) score and/or Clinical Opiate Withdrawal Scale (COWS) score as applicable, current withdrawal symptoms, and results of UDS. You must also attach the Regional Assessment and Referral Form (RARF) or other demographic and clinical information on which the admission decision was made. Requests must be received by **noon** of the last authorized service day. Failure to submit timely SARS may result in non-covered service days.

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

Criterion V Reviews

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

Retrospective Authorization

In the event that you admit a patient who was not Medicaid eligible on or before admission and the patient received retroactive Medicaid eligibility that would cover the inpatient stay, you can request a retrospective authorization review as follows. You must submit **a cover letter, a print screen from NC Tracks showing the date of Medicaid eligibility determination** and a **paper copy of the full closed medical record** (discs are not

accepted) to the following address within 30 days of the eligibility determination (or longer time if specified in your contract – you are responsible for being familiar with the requirements of your contract with Vaya):

Vaya Health
Attn: Inpatient Review Team
P.O. Box 247
Waynesville, NC 28786

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

Treatment Coordination and Discharge Planning Requirements

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

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

- You must regularly schedule treatment and discharge planning meetings for members in 24 hour inpatient care.
- You must provide Vaya and the member's BHCH or other designated community behavioral health provider with at least 24 hours prior notice of the date, time and place of any treatment team or discharge planning meeting regarding a Vaya Health Plan member. If a member declines to permit notice to Vaya or the provider, this must be documented in the medical record.
- You must allow any assigned Vaya care coordinator, hospital liaison, crisis coordinator, BHCH or designated community behavioral health provider to attend and actively participate in treatment team and discharge planning meetings regarding members. If a member declines to permit access to Vaya or the provider, this must be documented in the medical record.
- You must notify Vaya, the BHCH and/or the designated community behavioral health service provider at least 24 hours prior to the intended date and time of any discharge of a member from inpatient care. If a member declines to permit notice to Vaya or the provider, this must be documented in the medical record.

- In those instances where formulary medication was used previously and proven ineffective for a member, you must request a pharmacology consultation by contacting Vaya's Chief Medical Officer prior to discharge. The consultation process will include review of available treatment alternatives that can facilitate ongoing medication adherence and effective treatment. **Medicaid members should not be discharged with prescriptions for medication that is not covered by Medicaid.**
- Once the discharge date is determined, you must schedule a follow-up appointment with the BHCH or designated community behavioral health service provider (if the member has an active treatment relationship pre-dating admission) or request that Vaya's Customer Services department do so. The follow-up appointment must be scheduled to occur within five (5) days of discharge.
- At the time of discharge, you must complete the discharge module in AlphaMCS and upload documentation of reconciliation and depart summary into the Patient Module in AlphaMCS.
- At the time of discharge, you must provide the member, Vaya, and the assigned community behavioral health provider with the following critical patient discharge information:

    - Reason for hospitalization;
    - Significant findings;
    - Procedures and treatment provided;
    - Admission and discharge diagnoses;
    - Member's demographic information;
    - Member's discharge condition (including level of risk to self/others);
    - Discharge medications and Medication Reconciliation Form (dosage and amounts, when refills needed);
    - Recommended follow up care (both medical and psychiatric);
    - Recommended revisions to Comprehensive Crisis Plan (if any);
    - Name of discharging physician with contact information; and
    - Any other information requested by Vaya at the time of discharge.

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

Section 11: Involuntary Commitment

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

Involuntary Commitment Process

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

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

What are the criteria for involuntary commitment? In order to file a petition for involuntary commitment, the petitioner must have knowledge that the person is mentally ill and dangerous to self or others OR is a substance abuser and is a danger to self or others. Please note that an intellectual/ developmental disability in and of itself is no longer considered sufficient criteria for commitment.

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

Where, how and when is the petition filed? Every county has its own procedure, so it is important to check with the Clerk of Court's office where the petition is to be filed before initiating the process. The petition must be filed in the county where the individual resides. IVC petitions are generally taken out with the Clerk of Court or local Magistrate. In some counties only the Magistrate can accept an IVC petition. The petition can be filed at any time, including after regular business hours. After hours petitions are always taken out with the local Magistrate. Contact information for Clerks of Court and Magistrate's offices are available on county websites and through the Administrative Office of the Courts: http://www.nccourts.org/ (click on "Courts" → "Court Information by County" → "Court Telephone Directory").

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

What happens after the individual is picked up by law enforcement? The individual must receive an evaluation from a "first evaluator" within 24 hours of presentation to the facility. The first evaluator can be a physician, psychiatrist, eligible psychologist or Certified First Evaluator or First Commitment Evaluator (certified through a rigorous process- LCSW, LCAS with limitations, or psychiatric NP). The first evaluator can do one of the following: (a) stop the process and release the respondent if the evaluator determines the individual does not meet IVC; (b) recommend inpatient mental health commitment; (c) recommend outpatient mental health commitment; or (d) recommend substance abuse commitment. If recommending substance abuse commitment, the first evaluator can release respondent pending hearing and refer to an outpatient provider, or hold the respondent at a 24 hour facility pending court hearing (24-hr treatment facility must be named on the form and accept respondent). The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using Form 572: Examination and Recommendation to Determine Necessity for Involuntary Commitment.

What happens if the first evaluator recommends inpatient commitment? If the evaluator recommends inpatient commitment, law enforcement must transport the respondent to a 24 hour facility (inpatient unit) for care and treatment. If a 24 hour facility is not immediately available OR appropriate to the respondent's medical condition, the respondent can be temporarily detained under appropriate supervision at the site of the first evaluation for up to 7 days from issuance of custody order **OR** released upon further examination by a physician, psychiatrist or eligible psychologist:

- If 7 days pass, the commitment process is terminated at that time or can be restarted with new petition. If doctor or eligible psychologist is new petitioner, the doctor or psychologist must conduct a new examination and may not rely upon prior examination.

The interim evaluation cannot be performed by other mental health professionals who perform initial examinations under the waiver. The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using Form 572: Examination and Recommendation to Determine Necessity for Involuntary Commitment, and a Notice of Commitment Change form.

What happens when a 24 hour facility is located? The 24 hour facility must accept the respondent for admission. Once that occurs and the respondent is transported, an MD evaluator must complete a second evaluation within 24 hours of presentation to the 24 hour facility. The second evaluator can stop the process and release the respondent if the evaluator determines the individual does not meet IVC, recommend inpatient mental health or substance use commitment, or recommend outpatient mental health or substance use commitment and release pending a hearing for outpatient commitment. The individual may also be given the option to sign in voluntarily. The decision to release or recommend outpatient MH or SA commitment must be

documented and reported using Form 572 and the Notice of Commitment Change Form. If the respondent is released, he or she is returned home via law enforcement, or may arrange their own transportation. **Network Providers may not decline inpatient admission based on an individual's transportation options post-discharge.**

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

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

Can an OPC be initiated without first requiring the respondent to be committed for an inpatient stay? Yes. An OPC can be initiated during the involuntary commitment process by an MD/ Licensed Psychologist on the first evaluation after the initial petition and not as part of any facility discharge. In such cases:

- The first evaluator must complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment form, check all appropriate Outpatient Commitment boxes in all sections, and identify the name and address of the proposed outpatient treatment provider, using Form 572.
- The first evaluator must also give the member an appointment time and date for the follow up examination with the outpatient treatment provider.
- The Initial Petition and the First Evaluation must be returned to the Clerk of Court prior to the follow-up appointment with the proposed provider.
- The Clerk of Court will schedule a hearing and notify the respondent and the proposed outpatient treatment center of the hearing date.
- If the member fails to show for the follow-up OPC appointment, the proposed provider must attempt follow-up and, if that fails, may file a Request for Transportation Order and Order (Outpatient Fails to Appear for Pre-hearing Examination AOC-SP-224), available here: http://www.nccourts.org/Forms/Documents/853.pdf.
- The proposed provider's MD/Licensed Psychologist must complete another Examination to determine if the individual continues to meet the criteria for OPC.
- If the member is still in need of an OPC, the proposed provider MD, Licensed Psychologist or designated clinician will attend the OPC hearing where the judge decides whether or not to continue the OPC. In some instances, the judge may order the examining MD or Licensed Psychologist to provide face to face

testimony at the OPC hearing. This OPC hearing is held within ten days of the initial MD's evaluation.

- If the member shows up for the follow up examination appointment and no longer meets the criteria for OPC, the MD/Licensed Psychologist should complete the Notice of Commitment Change form and send to the Clerk of Court, with a copy to the assigned Vaya care coordinator. This form is currently available on the archived DHHS website at: http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/formsforfacilies/form-5-79-01commitchge.pdf.

Outpatient Commitment Responsibilities

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

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

You must perform a face-to-face assessment within 5 working days of notification that a member you are serving is under OPC order, followed by ongoing outpatient face-to-face assessment and follow-up treatment at the level clinically appropriate to the member's needs and condition. Some members may need daily contact while others may need weekly contact. No member shall be seen less than once every two weeks unless they are in a 24 hour supervised (Family Care Home, Group Home) setting and are stable. If you determine that the member can be seen less than bi-weekly (two times per month), then a MD/Licensed Psychologist/FNP/PA must assess the need to continue the OPC and document the contact.

What is the process if a Network Provider is considering discharging a member on OPC? If you determine that the member no longer meets criteria to continue the OPC, then the MD/ Licensed Psychologist/ FNP/ PA must complete a Notice of Commitment Change form Once completed, you must send one copy to the Clerk of Court in the county the Court Order dictates (which is the county of supervision) and one to the assigned Vaya care coordinator who will log the termination of commitment. If the member was initially committed as a result of conduct resulting in the individual being charged with a violent crime, including a crime involving an assault with a deadly weapon, and was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk

of Court for clarification.

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

What if the member fails to comply but does not clearly REFUSE to comply with treatment? If the member fails to comply but does not clearly refuse to comply, i.e., the individual has a pattern of scheduling appointments but does not show up, you may request the court to order the member taken into custody for the purpose of a face to face evaluation. This option is only available if you know where the member can be located. To do this, you must complete a Request for Transportation Order and Order (Outpatient Fails but Does Not Clearly Refuse to Comply with Treatment AOC-SP-220) available here: http://nccourts.org/Forms/Documents/857.pdf. It must be sent to the Clerk of Court where the commitment is being supervised, with a copy to the assigned Vaya care coordinator.

What if the member does not comply with treatment and cannot be located? If the member is non-compliant and cannot be located for a pick up order, then you must attempt the following reasonable professional efforts:

- First, you must be able to demonstrate supporting documentation and/or billing for at least one of the following **within 72 hours (not including holidays/weekends)** of the initial missed appointment:
    - a face-to-face visit in the member's home
    - a rescheduled office appointment with the clinician that the member keeps
    - a phone conversation with the member about the services being offered
    - at least one face to face attempt to contact the member at his or her last known address
    - a follow-up letter sent to the member at his or her last known address
- Second, assuming the above-listed attempts to locate the member are unsuccessful, you must attempt face-to-face contacts once per week the first two weeks, then one more attempt two weeks later (4th week).
    - If the member's last known address is a homeless shelter or someone else who resides at the last known address states that the member does not reside at the last known address, the above three face-to-face attempts should be made at local homeless shelters. Any information provided to you by a family member or another person regarding the member's location must also be pursued).

What if these reasonable professional efforts are unsuccessful? You must document the efforts made, including three attempts at face-to-face contact over a 4-week period, in a letter to the Clerk of Court in the supervising county, complete a Notice of Commitment Change, and send to the Clerk of Court, with a copy to

the assigned Vaya care coordinator. Remember that if the member is initially committed as a result of conduct resulting in the individual being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the member was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court for clarification. If the member's case is active in AlphaMCS, you must keep the case open for 60 days from last contact. If the member cannot be located within 60 days from last contact, you may discharge the member from services and notify Vaya using the normal discharge documentation and procedures.

What is the review process for continuation of OPC? Prior to the expiration of the OPC, the Network Provider clinician must review the case with an MD/Licensed Psychologist/ FNP/ PA and determine if the member still meets the criteria for OPC and whether it needs to be extended. If the member has been compliant and no longer meets the criteria, then the duration of the OPC will naturally expire. If you determine that the member continues to meet the criteria for the OPC and a rehearing is needed, then the MD/Licensed Psychologist will need to complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment, form 5-72-09, available at http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/index.htm. This form, along with a completed Request for Hearing form, must be submitted to the Clerk of Court, with a copy to the assigned Vaya care coordinator.

What if the member moves to another state while under OPC? If the member moves to another state, you must document this change in the medical record, complete a Notice of Commitment Change and send to the Clerk of Court, with a copy to the assigned Vaya care coordinator. Remember that if the member is initially committed as a result of conduct resulting in the individual being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the member was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court for clarification.

What if the member moves to another MCO catchment area? If the member plans to relocate to another county within the state that is outside of Vaya's 23-county catchment area, you must request the Clerk of Court in the county where the OPC is supervised to schedule a hearing prior to the move. The MD/ Licensed Psychologist must complete a new Examination and Recommendation to Determine Necessity for Involuntary Commitment and send it to the Clerk of Court with a completed Request for Hearing, with a copy to the assigned Vaya care coordinator.

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

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

Substance Abuse Commitment

Involuntary Substance Abuse (SA) commitments generally take a great deal of coordination between community-based outpatient providers (SAIOP, SACOT, etc.) and potential inpatient treating facilities (state Alcohol and Drug Abuse Treatment Facilities, local Facility Based Crisis or detoxification facilities). An SA commitment order is a hybrid of inpatient and outpatient care. SA commitments are for 180 days, of which 45 consecutive days can be inpatient. If longer inpatient time is needed inpatient, a re-hearing must be held. At this hearing, 90 days can be ordered inpatient. Members under SA commitment who do not comply with treatment can be picked up by law enforcement, evaluated in the community and then admitted to a 24 hour treatment facility if inpatient criteria are met (without a new petition). In such cases, the Network Provider must complete Request for Transportation Order and Order (Committed Substance Abuser Fails to Comply with Treatment or is Discharged from 24-Hour Facility AOC-SP-223), available here: http://www.nccourts.org/Forms/Documents/854.pdf, and submit to the Clerk of Court, with a copy to the assigned Vaya care coordinator.

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

Section 12: Transition, Discharge and Provider Closures

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

Member Request

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

Change in Level of Care

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

Voluntary Provider Closure

In the event that a Network Provider is voluntarily closing a site, service or operations, the following information must be communicated in writing to ProviderInfo@VayaHealth.com:

- Whether the entire organization is closing, or only a part of it, and which part(s) or site(s), and also

whether you are closing all operations within the State of North Carolina;

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

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

Involuntary Provider Closure

In the event that Vaya decides not to renew your contract, site or service, or decides to terminate or suspend your contract, we will send you a written notice with guidance regarding member transition. It is not acceptable to interfere with or prevent member transition in such circumstances, or to discourage the member from transitioning to another Network Provider. The written notice will include a form you must complete and submit within 5 days of receipt of the notice in order to help us gather the following information:

- A list of the names and dates of birth of affected members and the services they are currently receiving;
- A list of members currently receiving medication management services, with prescription due dates. You are strongly encouraged to issue ninety (90) day prescriptions to individuals prior to closure or service termination, when applicable;
- Whether you made any arrangements for referral of Vaya members to other providers;
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals;
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals;

- A list of credentialed practitioners who will no longer be employed by you, if applicable; and
- A list of employees who will continue to have access to the AlphaMCS system during the closing process, including which specific functions within AlphaMCS, and the date such access should be terminated.

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

Closure Responsibilities

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

- If requested by the receiving provider, you must actively participate in treatment team, transition and/or discharge planning meetings until such time as all members in your care are transitioned or discharged.
- You may be subject to a final post-payment review to occur within 60 days of contract non-renewal/ termination/ withdrawal.
- You must submit a written plan for maintenance and storage of all records of services provided to Vaya Health Plan members at least 30 days prior to the end date of your contract, as well as a Master Records List that includes: Member's Name, Service Record Number, Date of Birth, Last Date of Service, Medicaid Number and County of Medicaid Origin, if applicable.
    - Records must be stored in an environment that ensures the continued preservation and safeguarding of records to protect their privacy, security, and confidentiality for the duration of the statutorily required record retention period.
    - The written plan must include a copy of your record storage log and documentation that outlines where the records are stored, the designated custodian of records, and contact information for the custodian of records.
    - Vaya has the sole discretion to approve or disapprove such plan. If the plan is not approved, we may require you to arrange for electronic or paper copies of such records to be transferred to our possession within 15 days of the request. You must provide a copy of the paper record storage log and contact information for a staff person who will assist with Vaya taking possession of the records. Records must be transferred in an organized and searchable format.
- Paper Record Storage Logs must include:
    - Name of Provider
    - Date of storage
    - Series/box number (Box 1 of 3)
    - Start date and the end date of the contents in the box
    - Record type or the name of the individual. Record type refers to the classification of the

particular information contained the box. Please store records of the same type in the same box.

- Record ID number or any other identifying number or information.
- Date of birth is recorded for individual service records. In the case of personnel records, the employee's date of birth is to be recorded for quick reference.
- Timeframe of the information stored in a particular box. For example, you would record an admission of 1/2/09 -9/13/09, or an employment period of 2/12/09 - 12/13/09 or a specific timeframe (e.g., October 2002 Cost Reporting, etc.).

- All claims for services must be submitted within 60 days of contract non-renewal/ termination/ withdrawal. Claims will be adjudicated on the published checkwrite schedule, unless Vaya suspends your final payment to ensure compliance with all transfer and closure requirements outlined in this Section:
  - If you fail to comply with member records transfer or other referral or transition obligations, we reserve the right to withhold any remaining payments that may be due until such time as the Vaya Legal & Compliance department approves release of funds.
  - If you fail to submit an acceptable records management plan, we reserve the right to withhold any remaining payments that may be due until such time as the Vaya Legal & Compliance department approves release of funds.
  - If you owe any outstanding overpayments or other amounts to Vaya, we will apply any remaining payments that may be due against your accounts receivable before releasing any funds remaining.

Records Retention

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

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

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

Section 13: The N.C. Innovations Waiver

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

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

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

What is the Registry of Unmet Needs? The Registry of Unmet Needs is a list of persons that are considered potentially eligible for NC Innovations.

What does potentially eligible mean? To be considered potentially eligible for NC Innovations, documentation of an intellectual disability or a closely related condition other than mental illness and information about the resulting impairment to adaptive functioning is required.

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

What does clinically significant mean? Clinically significant is usually defined as deficits in cognitive ability or adaptive function that is two standard deviations below what a typically developing person would score on

standardized tests that are administered by psychologists. With intelligence tests, a score of 70 is two standard deviations below the average. Scoring is similar for standardized tests of adaptive functioning.

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

What are the six major life activities?

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

How long do individuals wait for Innovations? There are currently over 1,000 persons waiting for Innovations Waiver services in Vaya's catchment area. Vaya is allocated a very limited number of slots each year by DHHS. The number of slots available varies based on a number of factors which include legislative actions regarding the State Medicaid budget, lifespan and support needs of current Waiver participants, and geographic location. **Vaya cannot fund slots using our 1915(b)/(c) Waiver savings.** Therefore, it is very difficult to predict the length of wait for Innovations services. While waiting, a person that is identified as potentially eligible may receive state funded I/DD services and/or services available due to the savings realized through managed care (Respite, Supported Employment and Community Networking funded through (b)(3) dollars).

Can someone be terminated from the Waiver? There are a number of reasons why Vaya might terminate a slot. For example, Innovations Waiver participants must receive at least one service per month to avoid possible termination from the Waiver. These services are authorized because they were determined necessary to ensure the health and safety of the person receiving services. If they are not being provided, we must question whether the person remains eligible, being mindful of the long waiting list for services.

Why is it called a Waiver? It is called a "waiver" because CMS waived some of the requirements of the Social Security Act that traditionally apply to Medicaid. For example, the Innovations Waiver includes services and

supports such as home modification and respite that are not within the scope of services traditionally covered by Medicaid.

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

Are there any guidelines or polices for the Waiver? DMA issued an Innovations Technical Manual to serve as a guide on June 25, 2012; this document was revised in September 2013 and ultimately replaced by Clinical Coverage Policy No. 8P, originally effective August 1, 2014. Clinical Coverage Policy No. 8P has been revised several times since coming into effect – it is your responsibility to stay abreast of changes to DMA Clinical Coverage Policies.

Will there be any changes to the Waiver? The Waiver was renewed and amended effective August 1, 2013, and a second Waiver amendment became effective November 1, 2016. Any changes to the Waiver must be approved by CMS and are posted to the DMA website for public comment.

Does the Waiver contain any service limits? Yes. Below is a summary of current limits. Note that some, but not all, limits may be exceeded for children under age 21 under the EPSDT benefit discussed at Section 6 of this Manual.

- The Innovations Waiver has a **$135,000.00** annual budget ceiling per participant established by DMA and approved by CMS. Any request to exceed that limit will result in denial of the plan. If an individual's needs cannot be met under the $135,000 cost limit, he or she should be evaluated for referral and placement in an ICF-IID.
- Adults over 21 who live in private homes cannot be authorized for more than 84 hours per week for any combination of community networking, day supports, supported employment, personal care in-home skill building, and /or Community Living and Supports.
- Children under 21 who live in private homes cannot be authorized for more than 54 hours per week during the school year, or 84 hours per week when school is not in session, for any combination of community networking, day supports, supported employment, personal care in-home skill building and/or Community Living and Supports. If the individual is 18 or older and graduated with a diploma graduation with a degree/occupational course of study/GED indicating a standard course of study) then the individual may access the adult level of limits on sets of services.
- Adult and child beneficiaries who live in private homes with intensive support needs may request authorization from the LME/MCO for up to an additional 12 hours per day of in-home intensive supports or Community Living and Supports to allow for 24 hours per day of support. There are specific criteria

for approval of this service based on the individual's assessment results and it must be reviewed every 90 days.

- Adults over 21 who receive residential supports cannot be authorized for more than 40 hours per week for any combination of community networking, day supports and supported employment services.
- Children under 21 who receive residential supports cannot be authorized for more than 20 hours per week during the school year, or 40 hours per week when school is not in session, for any combination of community networking, day supports and supported employment services.
- Individual Goods and Services cannot exceed $2,000 per plan year.
- Payment for attendance at classes and conferences may not exceed $1,000 per plan year for participants (under Community Networking).
- Reimbursement for attendance at classes and conferences may not exceed $1,000 per plan year for caregivers (under Natural Supports Education).
- Community Transition funds are limited to $5,000 over the duration of the Waiver.
- Assistive Technology Equipment & Supplies and Home Modifications are limited to expenditures of $50,000 over the duration of the Waiver.
- Vehicle Modifications funds are limited to expenditures of $20,000 over the duration of the Waiver.

Do all Waiver participants receive care coordination? Yes, we are required to assign a care coordinator to each Innovations Waiver participant. The care coordinator must conduct monthly monitoring visits to ensure the health and safety of individuals on the Waiver. Most monitoring is done face to face, although telephonic monitoring may occur as needed. The care coordinator also works with the family and service provider to develop and submit an Individual Support Plan (ISP) during the participant's birth month.

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

Are there copayments for Innovations Waiver services? No. There is no copayment for the services available through the NC Innovations waiver, but there may be a copayment for medical services reimbursed by DMA. A copayment is a fee that Medicaid beneficiaries are required to pay when they receive certain services.

Copayments often are $3.00 depending on the type of service. If the NC Innovations participant is unable to pay the copayment, many offices will allow the individual or family to open an account and pay the amount owed as a copayment at a later date. The following services may require a copayment for NC Innovations participants:

7. Visits to a medical doctor
8. Prescriptions
9. Specialist visits
10. Optical services and supplies
11. Clinic services
12. Hospital emergency room visits when emergency care is not needed
13. Dental services

Innovations Provider Responsibilities

Prior Authorization: All Innovations Waiver services, with the exception of Crisis Services, require prior authorization by Vaya. Innovations providers work with the assigned Care Coordinator to acquire prior authorization for services.

- Innovations providers are required to actively participate in the development of the ISP by attending meetings scheduled by the Care Coordinator and/or the person receiving Innovations Waiver services.
- An ISP will be developed at the time an individual is admitted. Services must be implemented within 45 days of ISP approval.
- A new ISP, to be implemented on the first day of the month following the individual's birth month, will be developed on an annual basis thereafter.
- The ISP is developed using a person-centered planning process and must verify a proper match between the participant's needs and the service and/or supports provided. All services, paid and unpaid (including natural supports) should be reflected in the ISP. Care coordinators will never ask someone to sign a plan of care the member or family disagrees with, but may provide education about Waiver limits.
- The ISP is signed by the Care Coordinator, the person receiving Innovations Waiver services and/or the LRP if applicable. Other persons that participate in the development of the ISP may sign if desired.
- Upon completion, the Care Coordinator submits the ISP to the Vaya Clinical Operations department for approval. The ISP must be reviewed against medical necessity criteria and service definitions found in DMA Clinical Coverage Policy No. 8P. The Care Coordinator also completes service authorization requests (SARs) for each distinct service in the Alpha MCS system.
- The Innovations provider is responsible for ensuring prior authorization is acquired prior to the provision of Innovations Waiver services. The Innovations provider must implement services on the effective date of the authorization within the parameters outlined in DMA Clinical Coverage Policy No. 8P - NC Innovations.

Planning Responsibilities: All Innovations providers are required to actively participate in the person-centered

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

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

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

Deviations are made only at the request of the participant – not for provider convenience. Deviations must be documented by the provider agency. If there is to be a routine/ongoing deviation to the schedule due to changes in the participant's wants or needs, it is recommended that the person-centered planning team update the weekly schedule to reflect the change. Such updates will encourage better communication between all parties. Under no circumstances should the schedule be amended based on the needs of the provider agency. Unless there is a change to the total number of hours per year, the updated schedule would not need to be submitted to or approved by Clinical Operations but would be uploaded into the electronic record by the Care Coordinator. Once the schedule is established, only changes initiated by the participant or LRP may occur. Back-up Staffing Incident reports must be completed for all deviations that are not service breaks. Post-payment reviews and routine monitoring reviews will audit documentation of deviations from the schedule and a Plan of

Correction may be required. Clear notation on grids, services notes, or on a QP communication log regarding episodic changes at the participant's/LRP's request serve as evidence of adherence to the intent of the Innovations Waiver.

Documentation: Innovations providers are required to document services as outlined in the DMH/DD/SAS Records Management & Documentation Manual, APSM 45-2, and as specified in this Provider Operations Manual. This includes, but is not limited to, adequate documentation of required staff training and service notes that include time in/ time out.

Back-up Staffing: During the person-centered planning process, an agency Back-up Staffing Plan is developed. The Innovations provider Back-up Staffing Plan for services authorized must be indicated in the "Agency Back-Up (mandatory)" section of the ISP. The Innovations provider is required to provide this information during the person-centered planning process. The ISP should also explain how the person receiving services needs shall be met when there is failure to provide back-up staffing, especially in the event of an emergency. The person receiving services cannot waive the Innovations provider's responsibility to identify the mandatory Back-up Staffing Plan. However, the person receiving services may choose to decline back-up staffing offered by an Innovations provider. Failure to provide mandatory agency back-up staffing is considered a Level 1 Incident. When a back-up staffing incident occurs, the Innovations provider agency must submit a Back-up Staffing Incident Report within 72 hours of the incident into the AlphaMCS system. Questions about Back-up Staffing Incident Reports should be addressed to incidentreport@VayaHealth.com. The Back-up Staffing Incident Report is required when:

- Scheduled services do not occur because no back-up direct support professional is available.
- The person receiving services declines the back-up direct support profession offered by the provider agency

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

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

Service breaks do not require the submission of a Back-up Staffing Incident Report. Service breaks occur when a

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

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

Guidance for Using Protective Devices

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

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

1. During development of the ISP, the team will consider all material supports the person needs to live successfully in the community. These needs will be documented in Section B – Material Supports of the Risk/Support Need Assessment. The identified material support needs will be discussed by the ISP team. Some material support needs may be identified as a protective device. Each material supports considered in the discussion must be identified as either a protective device or behavioral control in the Medical/Behavioral "What others need to know to best support me…" section of the ISP.
2. If a material support is identified as a protective device, the provider agency must review the material support(s) through their Human/Client Rights Committee annually in conjunction with development of the ISP.
3. If any member of the person's ISP team expresses concern that the material support is being used for behavioral control, the provider agency must review the material support through their

Human/Client Rights Committee in accordance with 10A NCAC 27E .0104.

4. When the Care Coordinator is monitoring services, the participant/LRP signature on the ISP will constitute consent for material support items deemed protective devices by the ISP team. Material items that are deemed protective devices will not automatically be considered a restrictive intervention. However, if monitoring reveals that a protective device appears to be used for the purpose of behavioral control, the Care Coordinator will complete an investigation referral. If monitoring reveals potential abuse or neglect of the participant, the Care Coordinator will file an APS report with the applicable county Department of Social Services.

Relative as Direct Support Employee (RaDSE)

The NC Innovations Waiver is designed to leverage existing natural and community supports while fostering the development of stronger natural support networks. This enables Innovations participants to be less reliant on formal support systems. However, there are times when it is necessary for relatives/LRPs who share a home with the Waiver participant ("relative") to provide paid supports in order to ensure that the participant is able to remain in the home and community of his/her choice, particularly in our more rural communities. LRP refers to the court appointed guardian for an adult who is adjudicated incompetent.

For this reason, DMA Clinical Coverage Policy No. 8P - NC Innovations allows for Innovations providers to employ relatives to provide Community Living and Supports services within specific parameters. A relative is defined as an individual related by blood or marriage to the Waiver beneficiary, but does not include biological or adoptive parents of a minor child, stepparents of a minor child and the spouse of a Waiver beneficiary. Waiver beneficiaries receiving Residential Supports are seen as being in an out of home placement and therefore not covered under the RaDSE policy in the Waiver.

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

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

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

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

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

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

Therefore, requests for relatives to provide paid supports will require documented efforts of attempts to find direct support professionals through multiple Innovations providers. Ordinarily, a relative will not be approved to provide more than 40 hours of paid supports per week (or seven daily units per week). The relative or legal guardian is not to be reimbursed for any activity that would be provided to a person without a disability of the same age. Additional paid supports by a relative may be authorized to the extent that another provider is not available or is necessary to assure the participant's health and welfare.

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

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

The procedure for prior approval must be initiated by the Innovations provider through DocuSign®: (1) at least 5 business days prior to a new RaDSE requesting to provide services; and (2) on an annual basis at least 4 calendar weeks prior to the start of the Waiver participant's plan year for a continuing RaDSE. Complete instructions and the link for beginning the process is available at http://www.VayaHealth.com/providers.asp?section=radse. The form requires the Innovations provider to enter detailed information that will provide Vaya with all information

necessary to approve or deny the request. Completion of the form will generate a prior approval request. The form will be reviewed for complete information and a decision rendered within 14 days. If the provider does not receive a timely response to its request, it is the provider's responsibility to follow up with Provider Network to determine the status of the provider's request for the RaDSE and ensure it receives approval. Please note this form is required to be submitted annually, and should be submitted in conjunction with the annual ISP. Approval in one year does not guarantee approval in subsequent years.

Vaya will review location information and attestations indicated on the request form and an authorization decision will be made based on this information. For approvals, the Innovations provider will receive the approved DocuSign® form. For denials, the Innovations provider will receive the denied DocuSign® form and a formal letter that explains the decision. Rejections due to improper or incomplete requests will not be followed by a formal letter. If the request is rejected because of incomplete information, the provider may resubmit. **Please note that the NC Office of Administrative Hearings determined that RaDSE decisions are not appealable, but you or the participant may file a grievance by calling the Vaya Customer Services Line at 1-888-757-5726.**

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

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

Questions regarding RaDSE requirements may be addressed to RaDSE@VayaHealth.com.

Alternative Family Living (AFL) Requirements

- The AFL provider must be an agency. Individuals and independent practitioners may not contract with Vaya to operate an AFL.
- The AFL provider must maintain personnel files for all employees, including documentation of required training(s), healthcare personnel registry and criminal background checks for both primary staff and back up staff.
- The AFL site must be the primary residence of the AFL Provider (includes couples or single person) who receives reimbursement for cost of care.

- If the AFL serves more than one member or a member under 18 years of age, the site must be licensed by DHSR. If the AFL is serving a single individual at an unlicensed site, they cannot provide services to another member while licensure is pending.
- A back-up Staffing Plan must be in place and the backup staff must be employees of the AFL provider.
- The AFL provider must cooperate with required annual Health and Safety Reviews completed by the Vaya Contract Performance Unit.
- AFL Providers must notify the assigned Care Coordinator prior to moving a member to a new AFL site. Failure to do so may result in adverse action, including but not limited to an overpayment finding and/or contract termination.
- All AFL Providers must meet Vaya insurance requirements, including coverage for General Liability, property and automobile liability.
- All documentation for service provision must meet requirements of Controlling Authority and be readily available for review upon request.

Section 14: Block Grant Requirements

If your agency receives Federal Substance Abuse or Mental Health Block Grant funds from Vaya, you are responsible for meeting federal Block Grant (FBG) requirements. It is your responsibility to know whether you receive these funds. In order to be eligible for Block Grant funds, you must be a nonprofit entity. You will be monitored by DMH/DD/SAS and Vaya for adherence to the FBG requirements. To ensure you are prepared to meet all requirements, please refer to the 2014 archived DHHS Block Grant audit information available here: http://www2.ncdhhs.gov/mhddsas/providers/Audits/2014samhblockgrant/index.htm and https://www.ncdhhs.gov/divisions/mhddsas/LME-MCO/audit.

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

Mental Health Block Grant Requirements

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

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

Substance Abuse Prevention and Treatment Block Grant Requirements

The following requirements must be implemented by Network Providers for individuals, services, and/or programs funded with Federal Substance Abuse and/or Prevention Block Grant dollars, as well as certain

programs funded with state service dollars. It is your responsibility to know the requirements that apply to your organization. Please note that this Section includes the general requirements that apply to all Substance Use Prevention and Treatment populations/ programs as well as specific population/program requirements. Additional requirements may be included in your contract with Vaya for specific programs or populations listed below. Please refer to the Scope of Work in your contract to verify any additional requirements. It is your responsibility to be aware of and comply with all requirements of your contracts with Vaya.

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

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

- The organization must make continuing education available to employees who provide services for this population, covering substance use treatment, state and federal confidentiality requirements and disciplinary action that may occur upon inappropriate disclosure.
- The organization must have in effect a secure system to protect member records from inappropriate disclosure in connection with any activity supported through FBG funds.
- The organization must have a Drug Free Workplace Policy in effect.
- The organization must complete initial and subsequent NC Treatment Outcomes and Program Performance System (NC-TOPPS) at required intervals.

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

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

Requirements for Programs that Provide Services to Pregnant Women:

- Admission preference shall be given for pregnant women.

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

<u>Requirements for Programs that Provide Services to Persons Identified as IV Drug Users</u>:

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

to be effective

- Select, train and supervise staff to provide outreach
- Contact, communicate and follow up with high risk substance abusers, their associates, and neighborhood residents
- Promote awareness among injecting drug users about the relationship between injecting drug abuse and communicable diseases such as HIV
- Recommend steps that can be taken to ensure that HIV transmission does not occur
- Encourage entry into treatment

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

- Priority shall be given to populations that are at risk of developing a pattern of such abuse.
- The organization must ensure that programs receiving priority develop community-based strategies to discourage use of alcoholic beverages and tobacco by individuals to whom it is unlawful to sell or distribute such beverages or products.
- The organization must develop and implement comprehensive prevention programs that include a broad array of prevention strategies directed at individuals not identified to be in need of treatment.
- Services must include activities and services provided in a variety of settings for both the general population as well as targeting sub-groups who are at high risk of substance use.
- In implementing these provisions, prevention providers shall use a variety of the following defined strategies:
    - Information Dissemination
    - Education
    - Alternatives
    - Problem Identification and Referral
    - Community-Based Process
    - Environmental
- The organization must use evidence-based prevention practices in the provision of services.
- The organization must deliver evidence-based programs to selected and indicated populations.
- Vaya will ensure that a total of 48 hours of Synar Amendment activities are conducted every 6 months through all contracted prevention providers. Synar Amendment activities are those designed to reduce youth access to tobacco products through community collaboration, merchant education, law enforcement and related activities or media/ public relations. At the beginning of each fiscal year, Vaya will notify each contracted prevention provider of the number of required hours that must be devoted to Synar Amendment activities per six months.

Work First/CPS Substance Abuse Initiative Requirements: This Initiative serves DSS Work First Program, Food and Nutrition Services and Child Protective Services referrals.

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

Juvenile Justice Substance Abuse Mental Health Partnership (JJSAMHP) Requirements:

- Each member must meet the requirements of the designated target population/benefit plan of Child Substance Abuse Disorder.
- For uninsured members, the organization must require documentation of application for NC Medicaid/Health Choice.
- The organization must have a signed, valid consent for release of information with Juvenile Justice for each child being served.

Section 15: Compliance and Quality Management

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

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

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

Compliance Program

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

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

For more information and guidance about your compliance responsibilities as a health care provider that accepts public funding, please refer to the U.S. Health and Human Services' Office of Inspector General "Compliance 101" page at: http://oig.hhs.gov/compliance/101/.

Vaya develops and maintains a written Compliance Plan that includes the OIG "Seven Effective Elements" and is approved by our Board of Directors. We have a designated Compliance Officer and Compliance Committee that are accountable to senior management, as well as procedures to ensure the compliance of Vaya and the Provider Network, including the establishment of monitoring and auditing systems that are reasonably designed

to detect conduct in violation of applicable federal and state laws, rules, regulations, guidelines, policies and standards.

Prevention of Fraud, Waste and Abuse

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

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

- Billing for services not provided – A provider bills for services or items never rendered or furnished.
- Medical identity theft – A provider uses stolen identity to bill for services not provided, including the billing of services allegedly rendered to someone who was discharged from care or is deceased.
- Billing for Unnecessary Services or Tests – A provider falsifies the diagnosis and symptoms on patient records and billings to obtain payments for unnecessary services, laboratory tests or equipment.
- Billing for services that lack documentation – A provider bills for services for which the provider knows that required documentation is absent or inadequate.
- Double Billing – A provider bills both Medicaid and a private insurance company (or member) for the same treatment, or two providers request payment on the same member for the same procedure on the same date.
- Upcoding – A provider bills at a level of complexity that is higher than the service actually provided or documented. For example, billing for 60 minute therapy sessions when you only spend 5 minutes or less with the member.
- Unbundling – A provider bills for services separately (using multiple procedure codes) rather than using the fixed daily “bundled” rate or single comprehensive code.
- Billing for Unreasonable or Inflated Hours - Inflating the amount of time a provider spends with patients, for example a psychiatrist that bills for more than 24 hours of psychotherapy treatment on a day.
- Falsifying Credentials – Mispresenting the license or credentials of a practitioner in order to bill Medicaid.
- Substitution of Generic Drugs – A pharmacy knowingly bills Medicaid for the cost of a brand-name prescription when, in fact, a generic substitute was supplied to the member at a substantially lower cost to the pharmacy.

- Billing for More Expensive Procedures than were Performed – A provider bills for a comprehensive procedure when only a limited one was administered or bills for expensive equipment and actually furnishes cheap substitutes.
- Kickbacks – A hospital requires another provider, such as a laboratory or ambulance company, to pay a certain portion of the money received for rendering services to patients in the facility. Or a provider induces Medicaid beneficiaries to enroll with the provider or request services in exchange for gifts or payments. Examples include gift cards, vacation trips, personal services and merchandise, leased vehicles, and direct payments.
- False Cost Reports – A provider includes personal expenses in its Medicaid cost reports. These expenses often include the cost of personal items.

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

Fraud is defined as "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law." 42 CFR § 455.2. The term "fraud" includes misappropriation and other irregularities including dishonest or fraudulent acts, embezzlement, forgery or alteration of negotiable instruments such as checks and drafts, misappropriation of an agency's, employee, customer, partner or supplier assets, conversion to personal use of cash, securities, supplies or any other agency assets, unauthorized handling or reporting of agency transactions, and falsification of an agency's records, claims or financial statements for personal or other reasons. The above list is not all-inclusive but intended to be representative of situations involving fraud. Fraud may be perpetrated not only by an agency's employees, but also by agents and other outside parties.

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

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

1. Overutilization of medical and health care and services.

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

For more information, please refer to the following helpful Fraud, Waste and Abuse toolkit for providers, created by CMS and available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf.

False Claims Act

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

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud, which is covered by a separate IRS whistleblower program. **Under the FCA, it is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.** As of August 1, 2016, False Claims Act civil penalties increased to between $10,781.40 and $21,562.80 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the Anti-Kickback Statute or Stark law.

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

The civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or former employees, patients, or competitors. Because you receive Medicaid funds, you are required to establish and implement an education plan for your employees, managers, contractors and agents, which

includes written policies and detailed guidance on the FCA, state false claims laws, and the rights and protections afforded whistleblowers under the FCA and its state counterparts.

Compliance Hotline

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

- Call the Vaya Confidential Compliance (Fraud and Abuse) Hotline at 1-866-916-4255 (24 hours a day, seven days a week, allows for anonymous reporting). Reports may also be made by calling any of the Vaya office numbers and asking for the Compliance Officer.
- Report online at https://www.integrity-helpline.com/smc.jsp (allows for anonymous reporting)
- Call the NC Medicaid fraud, waste and program abuse tip line at 1-877-DMA-TIP1 (1-877-362-8471)
- Call the U.S. Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477)

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

Continuous Quality Improvement

Vaya is committed to working in collaboration with our Network Providers to achieve the highest standards of quality in service delivery. We understand the important role of quality management in protecting members and promoting high quality treatment. We maintain a strong commitment to continual improvement of our programs and services and the services provided directly to members. A focus on quality requires basic principles, which include:

1. Commitment to the involvement of members in all areas and levels of the service system in regards to analysis, planning, implementing changes, and assessing quality and outcomes.
2. Commitment to strengthen systems and processes – By viewing the system as a collection of interdependent processes we can understand how problems occur and can strengthen the system as a whole.

3. Encouraging participation and teamwork – Every member of the system can help assure quality if they are included in processes and are empowered to solve problems and recommend improvements.
4. Decisions are based on reliable information – By collecting and analyzing accurate, timely and objective data we can identify system problems, implement changes and measure progress.
5. Improvement in communication and coordination – Various members of the system can work together to improve quality if they share information freely and coordinate their activities.

Vaya must comply with numerous quality, satisfaction, performance indicator and financial reporting requirements under our DMA and DMH/DD/SAS contracts, including requirements to measure and report indicators in the following domains: Access, Availability, Quality of Care, Quality of Services, Appropriateness of Services, System Performance, and Satisfaction. The Quality Improvement Committee (QIC) regularly and annually evaluates Vaya's performance on these measures. The Board of Directors also maintains a Performance & Quality Committee that regularly hears reports on these measures. In addition to our URAC accreditation reviews and regular reviews by the DHHS Intra-Departmental Monitoring Team (IMT), an External Quality Review Organization (EQRO) also monitors Vaya annually, as per Medicaid regulations.

Vaya maintains an established quality structure that ensures the participation of all persons and agencies involved in the service system. The QIC is a cross functional team which includes representatives from Vaya staff, members and Network Providers. The purpose of the Committee is to ensure that we are all working together to achieve system improvements, and to monitor the overall quality of services. Vaya, alone, cannot maintain quality. This partnership is critical for success. The Vaya QIC develops a single Quality Improvement Plan for the Vaya System with input and feedback from the QIC and other relevant stakeholders. The plan identifies organizational goals and includes program description, structure, authority, accountability, a requirement for a work plan and an annual report. Through the required Annual Report, Vaya makes available information about its performance to Network Providers, practitioners, members and stakeholders on the Vaya website. A printed copy of the information can be provided upon direct request to Vaya.

The continual self-assessment of services, operations and the development and implementation of plans to improve outcomes to member is a value and requirement for all Network Providers. You are required to be in compliance with all federal and state Quality Assurance and Performance Improvement standards, including but not limited to:

1. The establishment of a formal Quality Committee to evaluate services, plan for improvements and assess progress made towards goals. The assessment of need as well as the determination of areas for improvement must be based on accurate, timely and valid data. Your quality assurance (QA) and quality improvement (QI) system will be evaluated during the Routine Monitoring review conducted every 2 years.
2. Maintain and submit Client Rights Committee minutes if applicable
3. Development and submission of your annual Quality Improvement Plan

4. Participate in Performance Improvement Projects required under our DMA and DMH/DD/SAS contracts
5. Report Incidents and follow-up as needed
6. Cooperate with Vaya's grievance, monitoring and program integrity activities
7. Actively participate in provider and member satisfaction surveys

Satisfaction Surveys

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

Abuse, Neglect and Exploitation

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

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

N.C.G.S. §7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.
(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, **shall** report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention.

Definitions of abuse and neglect with respect to juveniles can be found here: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_7B/Article_3.html

N.C.G.S. § 108A-102. Duty to report; content of report; immunity.

(a) Any person having reasonable cause to believe that a disabled adult is in need of protective services **shall** report such information to the [DSS] director.

(b) The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information.

Definitions of abuse, neglect and exploitation with respect to disabled adults may be found here: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_108A/Article_6.html

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

Health Information Technology and Security

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

As a Network Provider and covered entity under HIPAA, you are required to comply with the federal *Security Standards for the Protection of Electronic Protected Health Information* (the HIPAA Security Rule) and the federal Breach Notification Rule. The HIPAA Security Rule established a national set of security standards for protecting "electronic protected health information" (e-PHI). The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting e-PHI. Specifically, covered entities must:

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

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

You are also required to have and maintain high speed internet connectivity, provide complete and accurate data in all submissions to Vaya, follow Vaya's technical support procedures including accessing the Service Desk, complete AlphaMCS Provider Portal Training, and sign and adhere to the AlphaMCS User Agreement. Use of AlphaMCS is a privilege and requires certain responsibilities, including the responsibility to prevent sharing of AlphaMCS logins, to ensure that your staff complete AlphaMCS Provider Portal Training, and to notify us if an individual with a login leaves your employment.

Health Information Exchange

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

Note that current legislation requires that by February 1, 2018, all Medicaid providers must be connected to the HIE in order to continue to receive payments for Medicaid services provided. By June 1, 2018, all other entities that receive state funds for the provision of health services also must be connected. For this reason, all Network Providers must be working towards compliance with North Carolina's HIE efforts and Medicaid EHR Incentive Programs, which provide financial incentives for "meaningful use" of certified EHR technology. For more information about the HIE, please refer to http://www.nchie.org/.

Documentation and Clinical Coverage Policy Requirements

All Vaya Network Providers are required to strictly adhere to the documentation requirements outlined in the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Medicaid service provision requirements are specified in Clinical Coverage Policies (CCPs) promulgated by DMA. Many of the CCPs also include specific documentation, training and other requirements. It is the responsibility of each provider to be

familiar with and follow CCP requirements. Unfortunately, Vaya monitoring activities identified trends of non-compliance with respect to the following. Please ensure that you and your staff understand and comply with these requirements as applicable to your delivery of services:

- In all instances where the CCP requires "annual" training this means that the individual must receive the required training at least once every 365 days NOT once each calendar year.
- In all instances where the CCP requires a service note for a specified period of time, the note must reflect at minimum the required amount of billable services. Non-billable services can be listed in the note so long as the required amount of billable services are fully documented. If the provider wishes to document non-billable activities, the service note must specify the time spent on billable versus non-billable activities.
    - EXAMPLE: The Intensive In-Home (IIH) service definition requires a service note documenting a minimum of 120 minutes of billable services in order for the provider to bill the LME/MCO for one unit of IIH. If the service note documents a total of 120 minutes but includes non-billable activities, then 120 minutes of *billable* activities are not documented and this may result in an overpayment finding.
- Failure to comply with the Face to Face contact, team composition or full time employee (FTE) requirements of any service definition will result in an overpayment finding. Individuals will not be considered to meet the FTE requirement if they are fulfilling additional roles within the agency or otherwise (for example, performing outpatient therapy, diagnostic or clinical assessments, or serving as Day Treatment staff) unless the agency can document that the individual spent at least 40 hours per week on FTE activities.
    - EXAMPLE: IIH services must be delivered by a three-person team. Only the Lead is required to have face to face interventions; however, there must be evidence that two additional team members participated in the treatment during that month of services, whether face to face or ancillary.
- Providers who deliver case management as a component of another enhanced service (e.g., ACTT, CST, Day Treatment, IIH) must ensure that therapeutic intervention(s) remain the primary focus of service delivery where clinically appropriate. A pattern of notes that only document case management (with little to no evidence that therapeutic services were provided) may trigger a review.

Monitoring to Ensure Quality of Care

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

Section 16: Audits, Monitoring and Investigations

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

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

While ensuring quality and preventing fraud, waste and abuse is the responsibility of every Vaya employee and provider, there are 4 designated Vaya teams that are primarily responsible for these activities: the Special Investigations Unit (SIU), the Contract Performance Unit (CPU), the Incident Response Team (IRT), and the Quality Improvement Team (QIT).

The Special Investigations Unit (SIU)

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

The SIU may conduct their investigations as a desk review or may begin the investigation at the provider's office (announced or unannounced). The first step in most investigations is to request records documenting service delivery. If you receive a request for records from the SIU, you must respond within the timeframe stated in the letter. The letter will also include a contact number for you to reach the investigator assigned to the case. If the

review of records from the initial request indicates a high percentage of out-of-compliance findings or reveals other concerns or potential waste or abuse, we may issue another records request to expand the scope of the review. Please call us if you have any questions about the records request or investigation process. If you do not return records as requested, we may determine that all claims reimbursed for the dates of service and individuals under review constitute an overpayment.

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

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

The Contract Performance Unit

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

- The Vaya SIU to review potential fraud, waste or abuse;
- Division of Health Service Regulation (licensure or healthcare personnel registry violations);
- DMA, DMH/DD/SAS or other behavioral health MCOs in North Carolina;
- CMS (for potential fraud, waste or abuse of Medicare funds);
- County Departments of Social Services (abuse, neglect, or exploitation);
- Provider Accrediting Bodies;
- Practitioner Licensure or Certification Boards; or
- Law enforcement.

Health and Safety Site Reviews: The Contract Performance Team conducts health and safety site reviews as part of the initial enrollment and re-credentialing process, whenever a Network Provider requests to add a new site to their contract, and whenever a complaint is received about the quality of office, facility or residential space or that indicates a member's life, health, safety or welfare is in jeopardy. The types of grievances that may trigger a site visit include but are not limited to: unsafe office environment, lack of handicap accessibility, abuse, neglect, exploitation, HIPAA/ confidentiality violations, lack of appointments including office hours, and lack of adequate and confidential waiting areas. We also complete annual site reviews of Alternative Family Living (AFL) sites in accordance with DHHS requirements.

During the enrollment site visit, we will evaluate your readiness to provide services using a Site Review Tool mandated by DHHS. Vaya requires that all Network Providers meet the following standards, at a minimum, for office sites where members are seen:

- Physical Accessibility: Sites are handicapped accessible
- Physical Appearance: Office site is well maintained, neat and clean
- Office hours are prominently posted
- Adequacy of waiting and offices/examining room space:
  - Waiting and Examining Rooms are well lit
  - Adequate seating is available
- Responsiveness of office staff (Wait time standards are met):
  - Scheduled appointment: Individual seen within one (1) hour
  - Walk-In: Individual seen within two (2) hours or schedule for subsequent appointment
  - Emergency: Individual seen within one (1) hour
  - Life-threatening emergencies: Individual must be seen immediately.
- Availability of Appointments:
  - 24 hour life-threatening emergency coverage for members under your care
  - Emergent care appointments within 2 hours
  - Urgent care appointments within 48 hours
  - Routine care appointments within 14 days
- Adequacy of Treatment Record Keeping:
  - Compliance with all Controlling Authority
  - Medical records shall be maintained in a secure/confidential filing system
  - Medical records shall not be commingled
  - Medical records shall contain legible file markers
  - Medical records are easily located

Routine Monitoring: Vaya evaluates Network Provider compliance and performance utilizing the DHHS Provider Monitoring Process for LME/MCOs. We must complete routine monitoring of every provider in our network at least once every two years. Routine is defined as "meeting compliance-based standards only." Independent practitioners, group practices and agencies which provide outpatient behavioral health services only are monitored using the DHHS Review Tool for Routine Monitoring of Licensed Independent Practitioners. All other

providers are monitored with the DHHS Review Tool for Routine Monitoring of Provider Agencies, using the sub tools required by the services which that agency provides.

Routine monitoring consists of completion of the routine monitoring tool and the post-payment review tool. For providers of services in licensed facilities which are monitored annually by DHSR, only the post-payment review tool is completed. For more information about the routine monitoring process, including the review tools, please refer to http://www.ncdhhs.gov/MHDDSAS/providers/providermonitoring/index.htm. We strive to be transparent throughout the Routine Monitoring process:

- You will be notified of the scheduled review date in writing 21 – 28 calendar days prior to the date of the review.
- You will be notified of the specific service records needed for the review no less than 5 business days prior to the date of the review.
- Reviews will include an opening and exit conference. Any follow up to be completed by the Network Provider or Vaya are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.** After the review is concluded, any additional information submitted will not be used to change any established scores or out of compliance findings, but may be considered in implementation of a plan of correction (if required).
- You will be notified in writing of the results of the Routine Monitoring within 15 days of completion of the review. Monitoring tools are scored automatically in accordance with the guidelines provided with the tools. The tools will state if you did not meet threshold standards.
- Vaya will issue a plan of correction or adverse action in response to any of the following failures to meet threshold standards:
    - Any score below 85% on a sub-tool or sub-section of the Routine Monitoring tool.
    - A score below 100% on the question regarding restrictive interventions.
    - Monitoring reveals systemic compliance issues as determined by Vaya.

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

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

- You will be notified in writing of the results of the Focused Monitoring within 15 days of completion of the review.

Post-Payment Reviews (PPR): The purpose of these reviews is to evaluate clinical documentation to ensure that services were provided appropriately within established benchmarks and clinical guidelines; and that those services are consistent with pre-authorization (when required) and the PCP / Treatment Plan.

PPR is a process that involves a retrospective review of a sample of services. Information from the member's record (including assessment information, treatment plan and progress notes) is evaluated against Medical Necessity Criteria. The outcome of these reviews may indicate: areas in which additional Provider training is needed; that services were provided that did not meet Medical Necessity; and situations where the member did not receive appropriate services or needed care.

NOTE: Vaya uses both Focused and Routine PPR, and a sampling process across Network Providers in its PPR methodologies.

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

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

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

What is a Plan of Correction? This is a written document developed by you in response to a Report of Findings from Vaya. The POC must specify how you will address each out-of-compliance finding, violation or deficiency identified by Vaya. The POC must be approved by the Contract Performance team as adequately addressing the issues in need of correction. Vaya will conduct monitoring to ensure that the plan is implemented and fully integrated into your operation(s) and that all deficiencies were corrected and are unlikely to re-occur. We follow the process and timelines outlined in the DHHS Policy and Procedure of the Review, Approval and Follow-Up of Plan(s) of Correction currently available on the archived DHHS website at: http://www2.ncdhhs.gov/mhddsas/statspublications/Policy/policy-acc002.pdf. Failure to submit or implement an acceptable POC or substantially minimize or eliminate deficiencies may result in sanction up to and including termination from the Network.

Incident Response Team (IRT)

Vaya is required to monitor certain types of incidents that occur involving Network Providers and providers who operate within our 23 county catchment area. An incident is an event at a facility or in a service that is likely to lead to adverse effects upon a client. Incidents are classified into several categories according to the severity of the incident. **Network Providers are required to report all level II and level III incidents in the State's Incident Response Improvement System (IRIS).** Failure to do so is a violation of your contract and the North Carolina Administrative Code. In addition, you must submit a summary of all Level I incidents to Vaya on a quarterly basis. Out of state providers must also submit paper copies of the incident report to DHHS and to Vaya.

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

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

Vaya receives and tracks all incident reports filed in IRIS that involve providers operating in our catchment area. Upon receipt, we review incidents for completeness, appropriateness of interventions, and achievement of short and long term follow up for the member and the Network Provider's service system. All member deaths and Level III incidents will be reviewed by Vaya's Critical Incident Review Committee (CIRC), which is chaired by our Chief Medical Officer. The CIRC may request more extensive documentation regarding the member if deemed necessary. You must cooperate with this process and submit records as requested. Network Providers are required to develop and maintain a system to collect and track documentation on any incident that occurs in relation to a member. If concerns are raised related to the member's care or services or your response to an incident, the CIRC will refer the matter for potential investigation.

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

Suspensions for Health and Safety

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

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

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

Adverse Actions

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

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

- Moratorium on the Expansion of Sites or Services: An administrative action whereby you may not submit an application to add additional sites or services to your contract, and may not respond to any Vaya procurement activity, including an RFP or RFI.
- Payment Suspension: An administrative action whereby we continue to process your authorizations and claims, but your payments will be suspended (wholly or partially) for a designated time period not to exceed six (6) months, unless payment suspension is required by 42 C.F.R. § 455.23, in which case the suspension period remains in effect until the N.C. Department of Justice Medicaid Fraud Investigations Division completes its investigation and/or legal proceedings related to the alleged fraud are completed.
- Probation (increased monitoring): An administrative action whereby you may be placed on probation with increased monitoring for a specified period of time, not to exceed one (1) year.

What is a Sanction? This is an action against a Network Provider based on professional competence or conduct or resulting in a change to your status within the Closed Network. Examples of potential sanctions include but are not limited to:

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

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

- The provider violated a contractual, legal and/or administrative requirement, including but not limited to documentation, billing or other requirements set forth in DMA Clinical Coverage Policies and Manuals and DMH/DD/SAS Service Definitions and Manuals

- The provider meets the “Substantial failure to comply” standard as defined by 10A NCAC 26C .0502(6)
- The provider violated professional and/or ethical standards, including tolerating or covering up such violations on the part of its employees
- The provider engaged in unlawful acts, including orchestrating, promoting, tolerating, or covering up any illegal activity on the part of its employees
- The provider is jeopardizing the health and safety of members

Automatic (Immediate) Termination

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

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

Notification of Adverse Action

We will always send you a written notice if we issue an adverse action. Depending on the nature of the decision, we may also call you. Notices will identify the nature and effective date of the adverse action, the basis for the decision, an explanation of how to initiate the dispute resolution process and how to submit additional information, and the timelines for doing so. All notifications are sent via electronic mail to the primary email contact on file with Vaya. If you do not signify acceptance of the email within 1 business day, the notification is sent via trackable mail. For purposes of calculating the appeal timeframes described in the next Section, we consider that correspondence is received by you on the date of the attempted email delivery, regardless of whether you signify acceptance, unless it was sent to the wrong address based on a Vaya error, in which case the date it was sent to the correct address shall apply.

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

Section 17: Dispute Resolution

Policy Statement

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

Unless resulting from a change in applicable laws, rules or regulations or State requirements requiring a shorter timeframe, we will provide you with at least thirty (30) days' notice of any significant revision to the dispute resolution process through notification to the Provider Advisory Council, a Communication Bulletin and associated website posting.

Scope

This dispute resolution process does not apply to appeals filed by a member, LRP, or personal representative (including a Network Provider) contesting decisions of Vaya to deny, reduce, terminate or suspend a covered service in accordance with N.C.G.S. Chapter 108D and 42 CFR Part 438, Subpart F. Those decisions are handled through Vaya's member reconsideration and appeals process explained at Section 6 of this Manual. This dispute resolution process is only available to Network Providers, with the exception of the process for contesting claim denials, which is open to all providers who submit claims to Vaya.

Can a Network Provider appeal every dispute it has with Vaya? No. The following issues may not be appealed through Vaya's reconsideration process and are not subject to dispute resolution:

- Refusal to process or denial of an initial application for credentialing;
- Credentialing effective date;
- Refusal to process or denial of a request to participate in the Closed Network;
- Refusal to renew or extend a provider's participation as a Network Provider beyond the terms of such provider's Network Contract(s);
- Refusal to process or denial of a request to add a site or service to an existing Network Contract;
- Refusal to award a service, program and/or funding as part of any Vaya procurement process;
- Any agreed upon adjustment to earnings targets for non-fee-for-service shadow claims;
- Issuance of a warning letter, educational letter, technical assistance letter, Report of Findings or Plan of Correction that does not change the provider's status within the Closed Network;
- A decision to place a provider on Prepayment Review;

- Formal report to oversight authorities of known or suspected violations, including but not limited to the following:
    - Federal Centers for Medicare and Medicaid Services (Medicaid or Medicare fraud);
    - DMA Program Integrity or the Medicaid Investigations Division of the NC Department of Justice (Medicaid fraud);
    - Division of Health Service Regulation (licensure or healthcare personnel registry violations);
    - DMH/DD/SAS (summary suspension and/or revocation of authorization to receive public funding for the provision of MH/IDD/SUD services);
    - County Departments of Social Services (abuse, neglect, and exploitation);
    - Provider Accrediting Bodies;
    - Practitioner Licensure or Certification Boards; or
    - Law enforcement.

Network Providers also may not appeal or initiate dispute resolution in response to a "direct and contractually or administratively explicit consequences" of violating a contract and/or administrative requirement, such as a contract termination or suspension based on the following:

- Notification from the U.S. HHS Office of Inspector General, NCDHHS, or other oversight agency, of exclusion from participation in state or federally-funded health care programs including Medicare, N.C. Health Choice, Medicaid in any state, or a Medicaid managed care program (including but not limited to a PIHP operated by another LME/MCO);
- Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services;
- Action taken by the NC Department of Health and Human Services or any of its Divisions to terminate, suspend or revoke a contract or provider status;
- Loss of required facility or professional licensure, accreditation or certification; or
- Federal, state or local funds allocated to Vaya are revoked or terminated in a manner beyond the control of Vaya for any part of the Contract period.

What can be appealed? This dispute resolution process is available to any Network Provider who wishes to initiate it in response to any of the following:

- Any Notice of Administrative Action, Overpayment or Sanction issued by Vaya against a Network Provider as described in Section 16 of this Manual;
- An emergency contract suspension or suspension of referrals issued by the Chief Medical Officer against a Network Provider to protect the life, health, safety or welfare of any member/ enrollee as described in Section 16 of this Manual;
- A Notice of Credentialing Action (NCA) issued by the Vaya Credentialing Committee to revoke or restrict the credentials of any Network Provider or credentialed practitioner (which may include an owner or managing employee of the Network Provider) as described in Section 3 of this Manual;
- Final notification of a Claim Denial;

- Payment withholding of a 1/12th shadow claim payment in regard to a non-Medicaid funded contract by and between Vaya and a Network provider
- Any other significant dispute that cannot be resolved informally and which has direct implications for the Network Provider, unless excluded as described above.

Any Requests for Reconsideration concerning disputes that do not obviously fall into a category listed above will be reviewed by Vaya for determination of whether it is a valid dispute, and if so, whether it should be categorized as administrative or clinical. If the appeal is determined to be invalid or untimely, Vaya will send you a written notification no more than fourteen (14) days following receipt of the Request. The letter will explain why the issue raised is not subject to the dispute resolution process, is untimely or is otherwise invalid.

Dispute Resolution Overview

There are three tracks for dispute resolution: Administrative Actions, Provider Sanctions and Claim Denials. Each track offers a mechanism for the provider to request a Reconsideration Review by a 3-person panel who was not involved in the initial or prior decision of the subject of the dispute. Providers may request a Reconsideration Review by at least one level of panel review. For requests for Reconsideration Review of a Provider Sanction or a Claim Denial, the provider may request review from a first and second level panel.

Reconsideration Reviews for Provider Sanctions shall include one panel member who is a clinical peer selected from the Vaya Closed Network (i.e. a practitioner with equivalent credentials or qualifications as the practitioner who initiated the appeal, or, with respect to agencies, facilities or hospitals, a qualified individual employed by a Network Provider that provides the same or similar services as are the subject of the dispute and/ or the provider that initiated the appeal). Peer participation is a requirement of Vaya's accrediting body.

Provider Sanction disputes are of a **clinical** nature that pertain to your professional conduct or competence in relation to matters such as, but not limited to, the following:

- The appropriateness or quality of professional services including assessment, treatment, consultation and referral;
- The appropriateness of interactions between a treating professional and a member; or
- Other professional conduct, including as required by laws, rules, regulations, contract requirements policy or manuals – e.g., failure to exercise professional judgment in disclosing therapeutic information.

Administrative Action disputes are of an **administrative or non-clinical** nature are those pertaining to matters such as, but not limited to, the following:

- Claims and billing;
- Adequacy of documentation, facility or staffing; or
- Compliance with laws, rules, regulations, contract requirements, policy, or manuals.

Disputes that are found in favor of the Network Provider at any level do not need to go to the next level. Reimbursement will continue during the dispute resolution process **unless** a payment suspension is issued for any reason, including receipt of a credible allegation of fraud or abuse (42 CFR § 455.23), or Vaya believes continued reimbursement is likely to increase any overpayment amount due.

How do I request reconsideration? A Reconsideration Request Form ("Form") will be included with any written notification of an administrative action or sanction you receive from Vaya ("Notice"), except for claim denials, which are discussed below. The Form will include the specific address for mailing. You can submit the request in-person, electronically or by mail to the address listed in the Form. The Form must be signed by someone with authority, i.e. the disputing practitioner or an Owner/ Operator/ Managing Employee of a provider organized as a corporate entity. The Form must be completed in its entirety, include detailed contact information, identify the specific action or actions which are being disputed, and explain your specific dissatisfaction with such action(s). **You must select the type of panel meeting you prefer (telephone, in-person, desk review), and identify all persons you plan to bring to the meeting.** Only one reconsideration request may be submitted per dispute or Notice.

What is the deadline to request reconsideration? You have 30 days to request reconsideration from the date of the applicable Notice. We will consider our action final if a fully completed and signed reconsideration request is not received at the address listed in the Form by 5:00 p.m. on the 30th day following mailing of the Notice. Extensions of the time for filing will not be granted. It is your responsibility to ensure delivery, and provide proof of mailing if needed.

What happens after I submit a request for reconsideration? If we receive a signed, complete, timely request, we will send you a written notification with the date, time and location of the panel meeting. If you are represented by legal counsel, the notice will be sent to your legal counsel and we will do our best to accommodate his or her schedule.

How do I submit additional documentation for consideration by the Panel? Any documentation you wish to be considered by a panel must be submitted electronically, either via secure encrypted email, through submission of a secure USB drive or through a secure File Transfer Protocol (FTP). Documentation will only be accepted within the following timeframes.

- For all Reconsideration Reviews, documentation supporting the justification for provider's position must be submitted at the same time the Reconsideration Request Form is submitted.
- Documentation may be accepted at the Reconsideration Review at the discretion of the Facilitator (which shall not be unreasonably withheld), and will only be accepted if the provider or Vaya brings six (6) paper copies for the panel to reference during deliberation. Vaya staff will not make copies on site, unless the Facilitator, in his/her sole discretion, approves of such request.
- For claim denials, documentation for the first level review must be submitted with the request for reconsideration. Documentation for the second level review must be submitted at least five (5) days prior to the date of the scheduled second level review.

Your time is valuable. If documentation you submit prior to the review supports overturning Vaya's decision, we will notify you and cancel the panel meeting.

Panel Meeting Process

Are all reconsiderations in person? No. You may request that your panel meeting be conducted by telephone, in-person or paper (desk) review. For reconsideration reviews specific to 1/12th shadow claim disputes, a desk review is the only type of panel meeting available.

How soon will the panel meeting be scheduled?

- For sanctions, the panel meeting will be scheduled to occur no later than 14 days from the receipt of a signed, complete Request Form, excluding paid Vaya holidays, unless there are documented extenuating circumstances for the Network Provider or Vaya.
- For overpayments, the panel meeting will be scheduled to occur between 60 and 90 days from the date of the Notice of Overpayment, excluding paid Vaya holidays.
- For non-Medicaid funded 1/12th shadow claims, the panel meeting will be scheduled to occur no later than 30 days from the receipt of the request for reconsideration, excluding paid Vaya holidays.
- For Level 1 reviews for Claim Denials, the panel meeting will be scheduled to occur no later than 60 days, excluding Vaya paid holidays, from the receipt of the Level 1 request for reconsideration, and no later than 30 days, excluding Vaya paid holidays, from the receipt of a Level 2 request for reconsideration.

The panel meeting may not be scheduled for a later date unless there are documented extenuating circumstances for the Network Provider or Vaya. If the reconsideration is postponed or otherwise rescheduled due to extenuating circumstances, the documentation due date does not change but you may be granted up to a fifteen (15) day extension on this deadline at the discretion of the Panel Facilitator.

Can I reschedule if needed? Once scheduled, panel meetings will not be rescheduled unless there are documented extenuating circumstances, which include but are not limited to death, serious illness, severe inclement weather, or unavailability of a clinical peer. If you need to request that a panel meeting be rescheduled, approval of the extension will be dependent upon your signed agreement that you will not use our decision to reschedule the panel meeting as a basis to challenge the validity of the reconsideration decision.

Do I need an attorney? We cannot make that decision for you. You may want to consider the amount or issue at stake. A Vaya attorney is usually present at all panel meetings, except for claim denial reconsiderations. However, panel meetings are informal and non-adversarial. Witnesses are not sworn and cross-examination is not permitted. You must notify us in advance of the number of persons who will be present. The number of participants may be limited in order to accommodate meeting room space. All participants will be required to sign our Visitor Log, which includes a confidentiality disclaimer.

How long will the panel meeting last? In general, the meeting time frame will be limited to a maximum of two (2) hours, with additional time scheduled for the panel to deliberate. For disputes involving a large volume of claims, additional time may be scheduled.

Is the meeting recorded? No. The meeting may not be recorded by audio or video means. A designated staff person will take minutes for the meeting.

What happens at an in-person panel meeting? The Panel Facilitator will provide an opening statement explaining the agenda and requesting all parties present to state their name and title. A Vaya staff person will first present our view of the dispute in an objective manner. You may then present a narrative summary of the facts, evidence or arguments in support of your position. It is helpful to refer to documentation or laws, rules, regulations or policies in support of your position. Vaya staff may then respond to your presentation as needed. Throughout the presentations the panel members will review relevant documentation and may ask you questions. Vaya's legal counsel may provide advice or counsel to Vaya staff or panel members at any point in the process. At the end of the meeting, the Facilitator will ask you to sign an Attestation acknowledging that the agenda and role(s) of each person present were explained, that all parties were able to present their information fully and in a fair and equitable manner, and that the anticipated timing for a written decision was shared.

What happens at a telephonic panel meeting? A telephonic meeting generally follows the same process as an in-person meeting. We will mail you the Attestation in advance of the meeting and ask that you return it via facsimile or email immediately following the meeting.

What happens at a desk review? Desk reviews consist of a scheduled meeting where the panel reviews documentation, deliberates and reaches a decision without hearing presentation(s) from Vaya staff or the Network Provider. While reviewing documentation, the panel may contact Vaya staff, legal counsel or providers to ask specific questions necessary to reach a decision. A designated staff person will take minutes for the meeting.

How and when does the panel reach a decision? Following the meeting, the panel will deliberate and vote on a determination to uphold, revise, or overturn the decision, or pend for more information. Vaya legal counsel may be present during the deliberation to answer legal questions. All three panel members must be present for a vote to take place, and determinations are reached by majority vote. Vaya's Executive Leadership Team is authorized to overturn or revise the decision of any Vaya reconsideration panel. Following panel deliberations, the Facilitator shall issue a decision notice based on instruction from the panel or ELT and following review by Vaya legal counsel. The written decision will be sent to you via secure electronic transmission no later than 14 days after the panel meeting, unless additional time is needed due to extenuating circumstances. The date of the decision letter is the date of the final decision by Vaya.

Are panel meetings confidential? Vaya is a government entity subject to the NC Public Records Act, N.C.G.S. Chapter 132. While there are some exceptions (for example Sensitive Information or competitive health

information), some of our written material can be produced in response to a public records request. We are also required to notify DMA whenever we terminate or suspend a provider's participation in our network. However, to protect confidentiality, uphold professionalism and preserve objectivity for second level panels, panel members and participating staff will refrain from discussing the review with providers, peers or colleagues who are not on the panel or directly participating in the process, except as necessary to respond to requests from members or their families/ caregivers impacted by the dispute.

Is the panel decision final? Other than first level claim decisions as outlined in the "Disputing Claim Denials" section below, panel decisions on administrative actions are final and may not be appealed any further with Vaya. However, if you are not satisfied with the first level decision issued about a sanction, you may request reconsideration by a second level panel within 10 days of the date of the decision. If you do not request a second level panel review by 5:00 pm on the tenth day after the date of the first level decision, the sanction decision will be final. Please note that Vaya will assess late payment penalties and monthly interest if you do not pay back an identified overpayment within 30 days after the issuance of a final overpayment decision.

How does the second level panel process work? Within 14 days from the date we receive a signed, complete, timely request for reconsideration of a first level decision, not including paid Vaya holidays, we will schedule a second level panel, unless there are documented extenuating circumstances for you or Vaya. We will notify you of the date and time of the scheduled panel meeting in writing. The second level panel will include different panel members, but otherwise the process is the same. Please note that the second level decision is final and may not be appealed further with Vaya.

Can I file an appeal with the Office of Administrative Hearings if I am dissatisfied with Vaya's decision? You will need to check with your legal counsel on options for appealing Vaya's final decision. Our position is that OAH lacks jurisdiction over disputes between Vaya and Network Providers.

Disputing Claim Denials

What is a Claim Denial? This is a request for payment that is received as clean and processed by Vaya but which does not meet all of the required criteria to be approved for payment. Notification of Claim Denials will be transmitted to you via Remittance Advice (RA) or other final notification of payment, payment denial, disallowance, payment adjustment, or notice of program or institutional reimbursement. You must submit all requests for reconsideration of Claim Denials within 30 days from this notification (usually the RA).

Where can I find the Reconsideration Request Form? The Level 1 Request for Reconsideration of Claim Denial form ("Level 1 form") can be found on the Vaya website or may be requested from a Vaya representative. The submitted form must include specifics regarding the claim(s) including but not limited to the member's name, member record number, date of service, service code, claim header information and all other relevant information regarding the claim. If a signed, complete Level 1 form is not received within the required 30 day period, Vaya's action to deny the claim is final without further written notification.

When will a panel meeting be scheduled? Level 1 Claim Denials are reviewed through a Desk Review process. Vaya will schedule a Level 1 Desk Review panel meeting within 60 days, not including paid holidays, from the receipt of a signed, complete and timely Level 1 form, unless there are documented extenuating circumstances for you or Vaya. Following the desk review, a decision will be made to uphold, overturn, adjust, or determine that more information is needed. The panel will issue a written decision within 60 days from the date of the Level 1 Desk Review. The panel may request additional time to issue the decision if necessary, or may request that a Level 2 meeting be scheduled in order to get more information.

What if I disagree with the Level 1 decision? If you are dissatisfied with the Level 1 reconsideration decision, you can submit a written request for a Level 2 reconsideration review. The form to request Level 2 reconsideration will be attached to the Level 1 reconsideration decision. You must submit a signed, complete Level 3 form within 30 days from the date of the Level 1 decision. In the Level 2 form, you must specify whether you will participate in the Level 2 reconsideration in person, telephonically, or by submitting additional documentation. If a signed, complete Level 2 form is not received within the required 30 day period, Vaya's decision is final without further written notification, unless the panel determined more information was needed during the Level 1 Desk Review.

When will the Level 2 panel meeting be scheduled? Vaya will schedule a Level 2 Desk Review panel meeting within 30 days, not including paid holidays, from the receipt of a signed, complete and timely Level 2 form, unless there are documented extenuating circumstances for you or Vaya. If you do not attend the Level 2 reconsideration review meeting (in person or by phone) or do not submit additional documentation as previously arranged, the Level 2 reconsideration will be dismissed and the Level 1 reconsideration decision will become final. Following the Level 2 review, a decision will be made to uphold, overturn, adjust, or determine that more information is needed. The panel will issue a written decision within 30 days from the date of the Level 1 Desk Review. The Level 2 Claim Denial Decision is final and may not be appealed further with Vaya. Please consult with your legal counsel on options for appealing Vaya's final decision.

Appendix A: PAC Code of Ethics

Vaya Health Provider Advisory Council Code of Ethics

PREAMBLE

The PAC shall facilitate an open exchange of ideas, shared values, goals, and visions and bring forward concerns and solutions while promoting collaboration, ethical operations, mutual accountability, and quality services. The PAC strives to achieve best practices to empower members within our community to achieve their personal goals. PAC members commit to:

- Assure that their staff adhere to this code of ethics;
- Provide support to other member agencies; and
- Advocate for the further development of resources on a local and state level for members served.

PURPOSE

PAC members agree to abide by this Code of Ethics. Member agencies shall:

- Become familiar with and encourage their Board of Directors, Owners, and staff to adhere and follow the Code of Ethics;
- Agree that actions which violate the Code would be considered unethical;
- Agree that a lack of knowledge is not a defense for unethical conduct;
- Strive to achieve the highest standards of professional conduct;
- Acknowledge that all member agencies be committed to best practices in their specific area through involvement with continued education and review of relevant research;
- Report in writing any direct knowledge of perceived violations of the code of ethics;
- Offer age appropriate services which promote dignity and empower the individual; and
- Reflect the beliefs, values, heritage, and customs of individuals supported by offering culturally competent services.

PAC Members will discuss known violations of standard ethical practices by members with the offending colleague or agency director. In the event that this does not resolve the issue, the member shall consult with the Ethics Committee of the PAC regarding their responsibility.

CORE VALUES

The PAC embraces the following core values, which serve as the foundation of the Provider Advisory Council:

- Integrity: Provide accurate and truthful representation.
- Competence: Honor responsibilities to achieve and maintain the highest level of professional competence for members and those in their employ.

- Professional Conduct: Promote the dignity and autonomy of the profession, maintain harmonious inter-professional and intra-professional relationships, and accept the profession's self-imposed standards. All professional relationships should be directed to improving the quality of life of the individuals who receive supports from the member agency.
- Individual Value, Dignity, and Diversity: Provide supports and services that promote respect and dignity of each individual supported.
- Social Justice: Assure that the right of individuals and those who make decisions regarding services to them are provided with complete and accurate information on which to make choices.
- Social Capital: Network Providers support the importance of Social Capital in each individual supported.
- Partnership: Network Providers will work together in partnership to develop and achieve an individual's desired outcomes.

ETHICAL PRINCIPLES

The following broad based principles are based on the Core Values of the PAC. These principles set forth ideals to which all Network Providers should aspire.

VALUE: INTEGRITY – Provide accurate and truthful representation.

ETHICAL PRINCIPLE: Network Providers will not knowingly permit anyone under their supervision to engage in any practice that violates the Code of Ethics. Network Providers will not engage in dishonesty, fraud, deceit, misrepresentation of themselves or other providers, or any form of conduct that adversely reflects on their profession, the PAC, or on the Network Provider's ability to support members professionally. Network Providers will not commit unethical practices that include, but are not limited to, deceptive billing, falsification of documentation, commission of a felony, gross neglect and fiduciary impropriety.

VALUE: COMPETENCE – Honor responsibilities to achieve and maintain the highest level of professional competence for themselves and those in their employ.

ETHICAL PRINCIPLE: Network Providers will represent their competence within their scope of practice. Network Providers will engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training, and experience. Network Providers will allow individual staff to provide only those services that are within the staff member's competence, considering the employee's level of education, training, and experience. Network Providers will demonstrate compliance with state and federal rules, regulations and laws regarding standards for training and credentials for supports provided.

VALUE: PROFESSIONAL CONDUCT – Uphold the dignity and autonomy of the profession, maintain harmonious inter-professional and intra-professional relationships, and accept the profession's self-imposed standard. All professional relationships should be directed to improving the quality of life of the individual who receives support from the member agency.

ETHICAL PRINCIPLE: Network Providers will not participate in activities that produce a benefit for themselves over the individuals they support or may potentially support, always giving priority to professional responsibility over any personal interest or gain. Network Providers will make all reasonable efforts to prevent any incidents of abuse, neglect and exploitation. Abuse means the infliction of mental or physical pain or injury by other than

accidental means, or unreasonable confinement, or deprivation by an employee of services, which are necessary to the mental or physical health of the individual. Temporary discomfort that is a part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse. Neglect means the failure to provide care or services necessary to maintain the mental or physical health and well-being of the individual. Network Providers will promptly report and thoroughly investigate all allegations of abuse, neglect, and exploitation. Under no circumstance will the support relationship between the program, staff, and individuals receiving services, and/or their families or legal guardian be exploited. Exploitation is defined as the illegal or unauthorized use of a service user or a service user's resources for another person's profit, business or advantage. Network Providers will train staff to recognize and report any suspected incidents of abuse and neglect and exploitation.

VALUE: INDIVIDUAL VALUE, DIGNITY AND DIVERSITY – Provide supports and services, which promote respect and dignity of each individual served.
ETHICAL PRINCIPLE: Network Providers will comply with all Federal and State rules and laws related to confidentiality and protected health information, including but not limited to, N.C.G.S. 122C; -52 through 122C-56, the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the HIPAA final administrative simplification regulations codified at 45 CFR Parts 160, 162 an 164; and 42 CFR Part 2. Network Providers will not discriminate in their relationships or services provided to individuals receiving supports, contractors, and colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability. Network Providers will provide individuals and families a means of submitting grievances that is fair and impartial. Network Providers will comply with N.C.G.S. § 35A – 1201, which allows for individuals who are adjudicated incompetent to be involved in decisions and choices that impact their lives. Network Providers will make all reasonable efforts to ensure individuals and families participate in the development and revision of any plan for services. Network Providers will not abandon individuals and families. Network Providers will consistently demonstrate efforts to assure that their services eliminate the effects of any biases based upon individual and cultural factors. Network Providers will support the recovery and self-determination of each individual.

VALUE: SOCIAL JUSTICE – Assure the rights of individuals receiving supports and others who make decisions regarding services are provided with complete information on which to make their choices.
ETHICAL PRINCIPLE: Network Providers will accurately portray their services and capacities through public and private statements. Network Providers will not engage in false and deceptive representation of their services. Network Provider's marketing strategies will not offer inducements to primary individuals receiving supports or their legal representatives in exchange for business gained. Network Providers will accurately portray their ownership, board of directors and management through public and private statements. Network Providers will follow required laws and standards regarding the hiring of staff. Network Providers will not make initial contact with employees of other providers for the purpose of offering employment to that individual employee for the purpose of gaining clients. This does not preclude the individual client to make a choice. Network Providers will use the standards means of advertising for hiring staff.

VALUE: SOCIAL CAPITAL – Network Providers support the importance of social capital for each individual supported.
ETHICAL PRINCIPLE: Network Providers will support and promote opportunities for individuals they support to develop valued relationships with members of the community in which they live or work. Network Providers will support and promote opportunities for individuals they support they be treated with respect and dignity within the community they live or work. Network Providers will support and promote opportunities for individuals they support developing roles in the community in which they live or work.

VALUE: PARTNERSHIP – Network Providers will work together in partnership to develop and achieve individual desired outcomes:
ETHICAL PRINCIPLE: Network Providers shall collaborate to share resources that enhance the functions of the Network to develop solutions for gaps in services and will work in partnership:

- To assure continuity of care for members, and
- To assure linkage for services, and
- With members, stakeholders, parents, significant others, and Vaya to support the attainment of each individual's goals

Appendix B: CC Center Model

Comprehensive Care Center Model

See http://www.VayaHealth.com/documents/providers/Comprehensive-Care-Centers.pdf

Appendix C: Provider Resources

Vaya Health Provider Resources

See http://vayahealth.com/providers/provider-resources/

Appendix D: Payment Protocol

Hospital Mixed Services Payment Protocol

Services	Claim Processing and/or Financial Liability
Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRGs)	**LME/MCO**
Outpatient X-ray and Lab Work	
• Prescribed by an LME/MCO network provider on an Inpatient basis such as: VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels. • Prescribed by LME/MCO network provider on an outpatient basis such as therapeutic drug levels.	**Bill direct to NC DMA / Medicaid** **EXCEPTION**: Bill LME/MCO for Eligible Beneficiary's services provided during Emergency Department visit for treatment is where Revenue Code is one of the following (450-459, 900-919) and the primary ICD-10 diagnosis code is within the **Designated Behavioral Health Range***
• Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared. • Other tests ordered by non-LME/MCO physician	**Bill direct to NC DMA / Medicaid** **EXCEPTION**: Bill LME/MCO for Eligible Beneficiary's services provided during Emergency Department visit for treatment is where the primary ICD-10 diagnosis code is within the **Designated Behavioral Health Range***
Drugs	
• Outpatient prescription drugs and take-home drugs	**Bill direct to NC DMA / Medicaid**
Ambulance	
• Transport to the hospital when the primary diagnosis is behavioral care • Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	**Bill direct to NC DMA / Medicaid**
• Transfers authorized by LME/MCO from non-network facility to a network facility	**LME/MCO**
Consults	
• Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit • Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	**LME/MCO**
• Medical/Surgical on Mental Health/Substance Abuse Unit	**Bill direct to NC DMA / Medicaid**
Emergency Room Charges – Professional Services	
• Emergency Department services billed with a Revenue Code range of 450-459, 900-919 for treatment where Primary Diagnosis is within the **Designated Behavioral Health Range*** • Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	**LME/MCO**

Services	Claim Processing and/or Financial Liability
• Emergency room services where the Primary Diagnosis is **NOT** within the **Designated Behavioral Health Range**	**Bill direct to NC DMA / Medicaid**
*** Designated Behavioral Health Primary Diagnosis Code Ranges: F01 - F99** (ICD-10)	
Emergency Room Facility Charge.	
• Emergency Department services billed with a Revenue Code range of 450-459, 900-919 for treatment where Primary Diagnosis is within the **Designated Behavioral Health Range***	**LME/MCO**
• Emergency room services where the Primary Diagnosis is **NOT** within the **Designated Behavioral Health Range***	**Bill direct to NC DMA / Medicaid**
Medical/Neurological/Organic Issues	
• Stabilization of self-induced trauma poisoning • Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders	**Bill direct to NC DMA / Medicaid** **EXCEPTION**: Bill LME/MCO for Eligible Beneficiary's services provided during Emergency Department visit for treatment where Primary ICD-10 Diagnosis is within the **Designated Behavioral Health Range***
Alcohol Withdrawal Syndrome and Delirium Tremens	
• Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by elevated vital signs, agitation, perspiration, anxiety and tremor that is associated with the abrupt cessation of alcohol or other addictive substances. • Detoxification services authorized by PIHP. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs except when services are provided in the emergency room and the primary diagnosis is within the Designated Behavioral Health Range*.	**LME/MCO**
Miscellaneous	
• Pre-Authorized, Mental Health, Alcohol/ Substance Abuse admission, History and Physical • Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or LME/MCO authorized physician	**LME/MCO**

* Designated Behavioral Health Primary Diagnosis Code Ranges: F01 - F99 (ICD-10)

Appendix E: Acronyms/Glossary

Commonly Used Acronyms and Glossary of Terms

1/12th payment	Also known as a capitation payment. This is a predetermined payment established by contract. It is disbursed to the provider in 12 monthly payments and is intended as a prepayment for state-funded capitation services. Providers submit claims to Vaya the same as a fee-for-service claim. Providers are not paid for individual capitated service claims; the claims serve as proof that a service was rendered.
Abuse	Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
Access to Care	The ability to obtain an array of available and needed treatments, services and supports
Accreditation	Certification by an external entity that an organization has met a set of standards
Adverse Benefit Determination	As defined in 42 CFR 438.400(b), adverse benefit determination (previously referred to as a managed care "action") means: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; or (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
Adjudicate	A determination to pay or reject a claim
Appeal	A request for review of an Adverse Benefit Determination
Authorized service	Medically necessary services pre-approved by Vaya Health
Basic benefit plan	The basic benefit package includes services available to Medicaid-eligible individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services provide brief interventions for individuals with acute needs. The basic benefit package is accessed through a simple referral from Vaya through its screening, triage and referral system.

Capitation	Also known as sub-capitation. A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof a service was rendered.
Care coordinator	Vaya employee assigned to conduct care coordination functions described at 42 CFR § 438.208(c), including referral, linkage, treatment and discharge planning
Catchment area	Geographic service area; a defined group of counties
Claim	A request for reimbursement under a benefit plan for services
Clean claim	A "clean claim" is a claim that can be processed without obtaining additional information from the service provider or a third party. It does not include a claim under review for medical necessity or a claim from a provider under investigation by a governmental agency for fraud or abuse.
Client	Also referred to as "consumer", "enrollee", "member" "participant" or "patient". Means an individual receiving services funded by Vaya or as defined in N.C.G.S. § 122C-3 (6).
CMS-1500	Health insurance claim forms. The CMS-1500 form is the official standard Medicare and Medicaid health insurance claim form required by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health & Human Services.
Coordination of benefits (COB)	Process of obtaining payments from third-party payors (such as primary or secondary insurance) prior to billing the payor of last resort.
Credentialing	The review process to approve applicants for participation in Vaya's network of providers
CSRA (formerly CSC)	The fiscal agent for the N.C. Department of Health and Human Services who is responsible for the State's MMIS
CUR	Client Update Request (AlphaMCS)
DDE	Direct data entry, such as keying a claim directly into AlphaMCS
Denial	A request for payment that is received as clean and processed by Vaya but that does not meet all required criteria to be approved for payment. It is transmitted to the network provider via a remittance advice (RA) or other final notification of payment, payment denial, disallowance, payment adjustment or notice of program or institutional reimbursement.
DMA	N.C. Division of Medical Assistance
DMH/DD/ SAS	N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DSS	(N.C.) Division of Social Services or (county) Department of Social Services
Dx	Diagnosis
ECS	Electronic claims submission
EDI	Electronic data interchange
Eligibility	A determination that a person meets the requirements to receive services as defined by the payor

Enhanced benefit plan	Includes services that are available to Medicaid-entitled individuals and non-Medicaid individuals meeting medical necessity criteria. Enhanced benefit services are accessed through a person-centered planning process. Enhanced benefit services are intended to provide a range of services and supports that are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance use and with more complex service and support needs.
Enrollment	Action taken by the N.C. Division of Medical Assistance (DMA) to add a Medicaid beneficiary's name to the monthly enrollment report. Also refers to an action by Vaya to add a non-Medicaid client to the Vaya non-Medicaid Health Plan.
Enrollment period	The timespan during which a beneficiary is enrolled with Vaya as a Medicaid waiver-eligible beneficiary
EOB	Explanation of benefits
Fee-for-service	A payment methodology that associates a unit of service with a specific reimbursement amount
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
HIPAA	The Health Insurance Portability and Accountability Act of 1996
I/DD	Intellectual and/or developmental disability
Licensure	A state or federal regulatory system for service providers to protect public health and welfare. Examples include licensure of individuals by professional boards, such as the N.C. Psychology Board or the N.C. Substance Abuse Professional Practice Board. Examples also include licensure of facilities that provide MH/IDD/SUD services by the N.C. Division of Health Service Regulation (DHSR). Licensure may apply to both individuals and facilities.
LME (Local management entity)	A local political subdivision of the state of North Carolina established under Chapter 122C of the North Carolina General Statutes that is responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.
Managed benefit	Services that require authorization from Vaya Utilization Management (UM)
MCO (managed care organization)	An umbrella term for health plans that provide healthcare in return for a predetermined monthly fee and coordinate care through a defined network of providers, practitioners and hospitals
N.C. Innovations Waiver	The North Carolina 1915(c) Home and Community-Based Waiver for people with I/DD.
N.C. MH/DD/SAS Health Plan	The North Carolina 1915(b) Medicaid Managed Care Waiver for M/IDD/SUD services.

NC START	N.C. Systematic Therapeutic Assessment, Respite and Treatment. NC START provides prevention and intervention services to adults with intellectual and/or developmental disabilities and complex behavioral health needs.
NC-SNAP	N.C. Support Needs Assistance Profile. NC-SNAP is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for developmental disability supports and services.
NC-TOPPS	N.C. Treatment Outcome Program Performance System. Refers to the program used by DMH/DD/SAS to measure outcomes and performance for substance use and mental health clients. NC-TOPPS captures key information on a person's current episode of treatment, aids in evaluation of active treatment services and provides data to meet federal performance and outcome measurement requirements.
Network Provider	A provider of MH/IDD/SUD services who is credentialed by Vaya and has a contract in effect for participation in the Vaya Closed Network to provide services to Vaya Health Plan members.
NPI (National Provider Identification)	A National Provider Identifier or NPI is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare & Medicaid Services (CMS).
NPPES	National Plan and Provider Enumeration System
Out-of-area provider	A contracted provider who delivers services to a Vaya Health Plan member outside of the 23-county catchment area
Out-of-network provider (OON)	A provider that has been approved as an out-of-network provider under Vaya's out-of-network policy and procedure and has executed a client-specific OON agreement with Vaya; however, these providers are not considered members of the Vaya provider network and are not available as service choices for Vaya members.
Overpayment	Any amount paid by Vaya to a provider to which the provider is not entitled, including, but not limited to, claims and expenses determined to be out-of-compliance. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.
Patient monthly liability (PML)	If a member's income is more than the cost of care in a long-term facility at the Medicaid rate, the member must contribute some income to the cost of care in the form of PML.
Place of service (POS)	Place of service; the facility or area where a service is rendered
Primary diagnosis	The most important or significant condition of an individual at any time during the course of treatment in terms of implications for the individual's health, medical care and need for services
Prior authorization	The act of authorizing specific services before they are rendered
Re-adjudication	A claim that has completed the adjudication process is queued for another adjudication in AlphaMCS. Process can be initiated on a claim-by-claim basis by claims specialist or in a batch adjudication by AlphaMCS.

Reconsideration	A review of a previous finding or decision by Vaya based on the provider's reconsideration request and any additional materials presented by the provider.
Recoupment	Any formal action by Vaya to begin recovery of an overpayment with ot without advance official notice by reducing future payments to a provider
Re-credentialing	The review process to determine if a provider continues to meet the criteria for participation in the Vaya Closed Network
Remittance advice (RA)	A document outlining claims status and payment that includes approved claims, denied claims, sub-capitated claims and recoupments (credit memos)
Replacement Claim	A replacement claim is essentially a new claim. It is submitted with a resubmit reference number, which is typically the claim header ID of the claim to be replaced. Once the replacement is submitted, the original referenced claim is automatically voided (reverted), and the new replacement claim replaces the original. This is used when a correction is needed on an approved original claim.
Revert	Also known as a 'void,' a revert renders the claim null and invalid. When a claim is reverted in AlphaMCS, it remains available for reference, but no further action can be taken with the claim. A revert can be performed standalone or as an automatic response to a submitted replacement claim.
Service authorization request (SAR)	A request for authorization of services. If approved, a SAR becomes an authorization.
Service location	Any location where a member may obtain a covered service from a Network Provider
Spend-down	Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time
STR	Screening, triage and referral. This also refers to a page in the AlphaMCS enrollment module.
Sub-capitated	Also known as "capitated." A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof that a service was rendered.
Third party payor	An individual, entity or program that is or may be liable to pay for all or part of the payments made by Vaya to a provider
Third-party billing	Services billed to an insurance company, Medicare or other third party payor
UB-04	The federal Office of Management and Budget and the National Uniform Billing Committee have approved the UB-04 claim form, also known as the CMS-1450 form. The UB-04 claim form accommodates the National Provider Identifier (NPI) changes.
Utilization management (UM)	A process based on medical necessity criteria to regulate the provision of services in relation to the needs of individuals. This process should guard against under-utilization, as well as over-utilization, of services to assure the frequency and type of services fit individual needs.