PROVIDER OPERATIONS MANUAL

2024-2025

Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan and NC Medicaid Direct PIHP

Effective July 1, 2024

VAYAHEALTH

Key Contacts

Provider Support Service Line • Provider information and technical assistance • 7 a.m.-6 p.m., Monday-Saturday, including holidays (toll-free)	**1-866-990-9712** provider.info@vayahealth.com
Member and Recipient Service Line • General information, benefits, referrals, and access to care • 7 a.m.-6 p.m., Monday-Saturday, including holidays (toll-free)	**1-800-962-9003/TTY 711** member.services@vayahealth.com
Behavioral Health Crisis Line • Crisis support and connection to Mobile Crisis Management • Available 24/7, every day of the year (toll-free)	**1-800-849-6127/TTY 711**
Nurse Line (Operated by Wellcare) • Help for Medicaid members with physical health concerns • Available 24/7, every day of the year (toll-free)	**1-800-290-1623/TTY 711**
Pharmacy Service Line (Operated by Navitus Health Solutions, Vaya's Pharmacy Benefit Manager) • Assistance for prescribers, pharmacies, and Medicaid members • 7 a.m.-6 p.m., Monday-Saturday, including holidays (toll-free)	**1-800-540-6083/TTY 711**
ADDITIONAL PROVIDER CONTACTS	
24/7 Compliance Hotline • Report fraud, waste, or abuse • Report suspicious billing	**1-866-916-4255** LegalandCompliance@vayahealth.com
Claims and Reimbursement • Billing and reimbursement • RAs, credit memos and service codes	**1-800-893-6246, ext. 2455** Claims@vayahealth.com
Eligibility and Enrollment • Health plan eligibility and enrollment • Member/recipient updates	**1-800-893-6246, ext. 2355** EandE@vayahealth.com
Credentialing	***1-800-688-6696 (NCDHHS NCTracks CSC Call Center)***
Utilization Management • Service definitions • Prior and retrospective authorizations	**1-800-893-6246, ext. 1513** UM@vayahealth.com
Member and Recipient Appeals • Peer-to-peer discussions • Reconsideration of authorization decisions	**1-800-893-6246, ext. 1400** Member.Appeals@vayahealth.com
Information Services Division (ISD) Service Desk • Vaya Provider Portal/software platform issues • Electronic billing (837/835)	**1-800-893-6246, ext. 1500** ServiceDesk@vayahealth.com
Complaints and Grievances • Report a grievance, complaint, or concern	**1-800-893-6246, ext. 1600** ResolutionTeam@vayahealth.com

Welcome to Vaya

On behalf of all of us at Vaya Health, I am pleased to present to you our Provider Operations Manual.

The work you do is critical for local communities, but it is not easy. Working together with you, alongside our Provider Advisory Council, we continue to develop and expand a strong network of services and supports to meet the needs of the individuals we mutually serve.

This manual contains vital information for providers and practitioners who deliver health care supports and services to Vaya members and recipients. It covers the Vaya Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan, which we call Vaya Total Care, as well as services provided through our NC Medicaid Direct Prepaid Inpatient Health Plan (PIHP).

Vaya Total Care is an integrated health plan designed for individuals with serious mental illness, severe substance use disorder, I/DD, and traumatic brain injury (TBI) needs. The plan also serves other special populations, including participants in the NC Innovations and TBI waivers, as well as people on the waitlist for these waivers, and includes management of State-funded (non-Medicaid) behavioral health, I/DD, and TBI services for uninsured and underinsured North Carolinians.

Through our NC Medicaid Direct PIHP, we manage behavioral health, I/DD, and TBI services for beneficiaries who continue to receive physical health and pharmacy services through the NC Department of Health and Human Services. Our Medicaid benefit packages feature the Tailored Care Management model, a community-based, provider-driven approach aimed at advancing whole-person care and better health outcomes.

Without providers to deliver care, Vaya would have no services to manage. Together, we are making a positive impact in the communities we serve across North Carolina today and for generations to come. Thank you.

Sincerely,

Tracy J. Hayes

Tracy J. Hayes, JD, CHC
Area Director and Chief Executive Officer
Vaya Health

Mission, Vision, and Values

MISSION: Who We Are and Why We Exist

Members are Our Mission. We manage publicly funded care for individuals with a serious mental health condition, severe substance use disorder, intellectual/developmental disability (I/DD), and/or traumatic brain injury (TBI), along with the medical, behavioral, and non-medical drivers of their health. We exist to benefit the lives of people with MH/SUD/IDD/TBI needs and connect them with the services and supports they need to live their best lives – the right care, in the right amount, at the right time.

VISION: What We're Building

Communities where people get the help they need to live the life they choose. We are committed to meeting local needs through collaboration with county partners, on-the-ground decision making, creative problem solving, and consistent follow-through. We focus on listening to each area's unique needs and developing solutions that will support the best outcomes for the individuals and communities we serve. 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.

VALUES: What We Believe In

We believe in the power of recovery, that peer support is a critical part of the care continuum, and that integrated, person-centered care is the best approach for treating each individual as a whole, unique person:

- We care about the individuals we serve and the people and organizations who serve them
- We are passionate about improving public health in the communities we serve
- We believe that healthcare should not be about profit
- We operate with integrity, which means ensuring quality care and accountable financial stewardship through ethical, responsive, transparent, and consistent leadership and business operations.

At Vaya, person-centeredness means interacting with compassion, cultural sensitivity, honesty and empathy; integration means caring for the whole person within the home and community of an individual's choice. We demonstrate our commitment by partnering with members, recipients, families, providers and other stakeholders to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better.

What's Inside

SECTION 1

About Vaya Health

Congratulations on joining the Vaya Health (Vaya) provider network! Our Provider Operations Manual offers detailed information and technical assistance to meet all requirements of network participation. A network provider is an appropriately credentialed provider of health care services who has a contract in effect for participation in the Vaya provider network as set forth at 42 CFR § 438.2.

Network participation means that you are listed in the Vaya Provider Directory and are eligible for referrals from Vaya. This does not include providers who are serving a member under an Out-of-Network (OON) Agreement. Participation is based on selection and retention criteria outlined in Section 6 of this manual.

Throughout this manual, the term "provider" generally refers to an institution or organization that provides services for Vaya members and/or recipients pursuant to a contract with Vaya. The term "practitioner" refers to a licensed or certified professional who provides medical, pharmacy, or behavioral health care services.

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 and practitioners, regardless of funding source. Some information also applies to providers who signed an OON Agreement. All references to timeframes in this manual refer to calendar days unless otherwise stated. A "business" or "working" day means Monday through Friday, 8:30 a.m. through 5 p.m., except for 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.

Within five days of approval from the NC Department of Health and Human Services (NCDHHS or the Department), Vaya will make this Provider Operations Manual available to contracted providers in an electronic version accessible via the Vaya website and/or the Vaya Provider Portal and in writing upon request of a contracted provider.

To provide suggestions or feedback about the information in this manual, please call Vaya's Provider Support Service Line 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 government agency that manages health care plans for eligible individuals in a 32-county region: Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rockingham, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey. We operated under the name Smoky Mountain Center for Mental Health, Developmental Disabilities and Substance Abuse Services beginning in 1972 and changed our name to Vaya Health in September 2016.

On July 1, 2021, North Carolina launched Medicaid Transformation, which is transitioning most Medicaid beneficiaries from fee-for-service Medicaid and NC Health Choice programs to an NC Medicaid Managed Care model. This model combines services for behavioral health, intellectual/developmental disabilities (I/DD), traumatic brain injury (TBI), physical health, pharmacy, and Long-Term Services and Supports (LTSS) under one of the following health plans:

- Standard Plans, which launched July 1, 2021, manage services for most Medicaid beneficiaries.
- Behavioral Health and I/DD Tailored Plans (Tailored Plans), which launch July 1, 2024, are designed for individuals with significant behavioral health, I/DD, and TBI needs as well as other special populations. Vaya's Tailored Plan is called Vaya Total Care.
- Eastern Band of Cherokee Indians (EBCI) Tribal Option.

Standard Plans, Tailored Plans, and the Tribal Option integrate physical health, behavioral health, and pharmacy services. Tailored Plans also manage services for North Carolina's non-Medicaid (State-funded) behavioral health, I/DD, and TBI services for low-income uninsured and underinsured North Carolinians. Individuals who receive State-funded services are called recipients. For more information about Medicaid Transformation and Tailored Plans, visit the NCDHHS Medicaid Transformation webpage.

Vaya also manages certain services for Medicaid beneficiaries carved out of managed care through the NC Medicaid Direct plan. Under this plan, NCDHHS manages physical health services, pharmacy, and LTSS, while Vaya manages behavioral health, I/DD, and TBI services. Information about NC Medicaid Direct can be found in applicable sections throughout this manual.

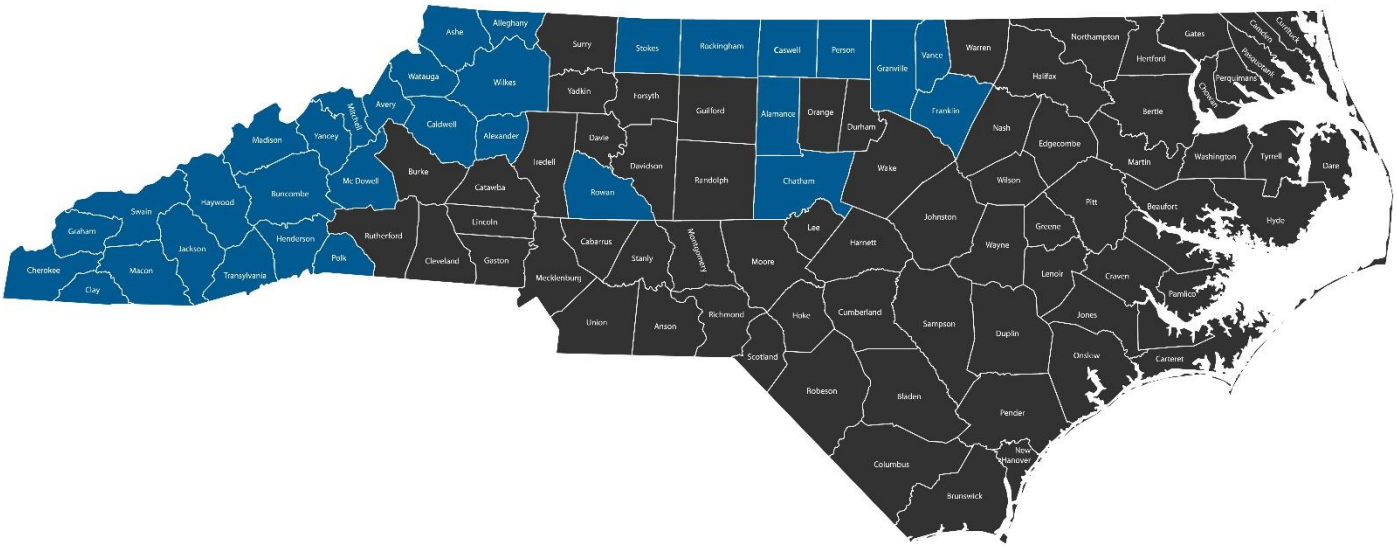
A central feature of Vaya Total Care for Medicaid members is the Tailored Care Management (TCM) model, a community-based, provider-driven model aimed at advancing whole-person care and better health outcomes. Through TCM, Vaya Total Care Medicaid members, as well as NC Medicaid Direct members who are eligible for TCM, have a single designated care manager supported by a multidisciplinary care team to provide integrated care management that addresses all identified needs, including physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet health-related resource needs. For more information, visit the NCDHHS TCM webpage.

Vaya operates on a capitated per-member per-month (PMPM) basis pursuant to a comprehensive risk contract with the NCDHHS Division of Health Benefits (DHB), also known as NC Medicaid, and in accordance with North Carolina's combined Medicaid Waiver, which includes an 1115 Service Delivery Waiver, a 1915(c) Home and Community-Based Services Waiver for individuals with I/DD who meet institutional level-of-care criteria (the NC

Innovations Waiver), and a 1915(i) State Plan Option Waiver. Vaya will also manage services for Medicaid beneficiaries enrolled in the TBI Waiver upon expansion of the TBI Waiver to the Vaya region.

Under state law, Vaya is responsible for the planning, development, implementation, management, and monitoring/ oversight of publicly funded behavioral health and I/DD services in a largely rural region that stretches from Cherokee County in the west to Vance County in the east.

Vaya Health Region



Vaya is currently accredited by URAC in the areas of Health Call Center, Health Network, and Health Utilization Management. We have begun the process to obtain Health Plan Accreditation with LTSS Distinction from the National Committee for Quality Assurance (NCQA), as required by NCDHHS, by June 30, 2027. We offer a Member and Recipient Service Line, a 24/7/365 Behavioral Health Crisis Line, and a Provider Support Service Line for all members, recipients, providers, and residents of our region. We also oversee a 24/7/365 Nurse Line (Vaya Total Care Medicaid beneficiaries only) and a Pharmacy Service Line (Vaya Total Care Medicaid members and prescribers only).

We ensure accessibility, availability, and quality of health care services through our network development, quality management, and monitoring and investigation efforts. This manual describes your roles and responsibilities related to each of these functions.

The 1115 Medicaid Service Delivery Waiver Model

The federal Centers for Medicare & Medicaid Services (CMS) approved the amended NC Medicaid 1115 Demonstration Waiver on Oct. 24, 2018. The waiver moves the state's Medicaid program toward whole-person care and gives North Carolina federal authority to implement through its managed care plans an innovative Healthy Opportunities Pilot (HOP) program to improve health and reduce health care costs. These pilots will identify the most cost-effective ways for managed care plans to deliver whole-person care and ensure Medicaid

dollars are purchasing value. The 1115 Waiver allows for regional Tailored Plans to manage whole-person health services and supports for individuals with significant behavioral health, I/DD, and/or TBI needs.

The NC Innovations 1915(c) Waiver

The Innovations 1915(c) Waiver is a home- and community-based services (HCBS) Medicaid waiver for people with I/DD, regardless of age, who meet institutional level of care criteria. This waiver allows long-term care services to be provided in home and community-based settings instead of an institutional setting, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Innovations Waiver includes some non-medical services, such as home modifications, which are not available under traditional Medicaid.

HCBS waivers are designed to help keep people out of institutions and promote independence, choice, community integration, and the ability to realize life goals. The Innovations Waiver incorporates self-direction, person-centered planning, individual budgets, participant protections (including monthly health and safety visits), and quality assurance to support the development of a strong continuum of services.

The number of Innovations Waiver participants is limited by CMS and by the availability of slots funded by the state of North Carolina. People who are potentially eligible for the Innovations Waiver may need to wait for funding to become available and are placed on the Registry of Unmet Needs. The registry is a first-come, first-serve list, and 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. Individuals who are placed on the Registry of Unmet Needs can access any non-Innovations services for which they are eligible. Vaya may also provide additional support for people placed on the registry. For more information about the Innovations Waiver, refer to Section 18 of this manual.

Where is Vaya Located?

Vaya's administrative headquarters are in Buncombe County, with additional regional office locations accessible to providers, community stakeholders, and members/recipients throughout our region. We also have staff co-located with county health departments, local Departments of Social Services (DSS), and network provider organizations. We also support a majority home-based workforce to ensure a local presence in every county in our region.

All Vaya offices and staff can be reached by calling 1-800-893-6246 (toll-free). Addresses and local phone numbers for additional offices are listed below.

BUNCOMBE COUNTY (ADMINISTRATIVE OFFICES)

200 Ridgefield Court, Suite 218, Asheville, NC 28806
Telephone: 828-225-2785
Fax: 828-412-4098

CALDWELL COUNTY COMMUNITY OFFICE

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

ALAMANCE-CASWELL COMMUNITY OFFICE

2929 Crouse Lane, Suite B, Burlington, NC 27215
Telephone: 336-513-4222
Fax: 336-229-2725

VANCE COUNTY COMMUNITY OFFICE

134 S. Garnett St., Henderson, NC 27536
Telephone: 252-430-1330
Fax: 1-877-342-6574

Governance and Administration

Vaya is governed by a Board of Directors appointed in accordance with N.C.G.S. Chapter 122C. Our Board includes two representatives from each of our four Regional Advisory Boards (which collectively meet the statutory requirement for a County Commissioner Advisory Board), a representative from each of our four Consumer and Family Advisory Committee (CFAC) regions, eight at-large members, three nonvoting members with special expertise, a member appointed by the NCDHHS Secretary, the president of the Vaya Provider Advisory Council, who serves in a non-voting ex officio capacity, as well as two non-voting members with special expertise (one representing the Eastern Band of Cherokee Indians, and one representing county Departments of Social Services). The Board provides broad oversight and policy direction for the organization and ensures that Vaya is accountable to community needs and local government. The Board actively and regularly reviews reports on finances, regulatory compliance, performance, quality, service utilization, member/ recipient services, unmet local service needs, access to services, and provider capacity.

Vaya's administrative structure includes the Area Director and Chief Executive Officer (CEO), Executive Leadership Team (ELT), numerous committees and cross-functional teams (CFTs), and internal departments responsible for broad functional areas. Vaya's ELT includes the CEO, as well as the General Counsel and Chief Compliance Officer (CCO), Chief Medical Officer (CMO), Executive Vice President (EVP) and Chief Information Officer (CIO), EVP and Chief Operating Officer (COO), the EVP and Chief Financial Officer (CFO), and the Chief Human Resources Officer (CHRO), all of whom report directly to the CEO.

REGIONAL BOARDS

Regional Boards serve as the chief advisory boards to Vaya and the CEO on matters pertaining to service delivery within Vaya's regions and provide input on appointments to the Board of Directors. In accordance with N.C.G.S. § 122C-118.2, each Regional Board consists of two individuals appointed by the Board of County Commissioners from each county in the region. Regional Boards serve in an advisory capacity only, and their duties do not include authority over Vaya budgeting, personnel matters, governance, or policymaking.

Advisory Boards

Vaya has several advisory boards and subcommittees that provide input and recommendations to the Board of Directors and executive leadership, including the Provider Advisory Council (PAC).

CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC)

The CFAC comprises individuals and family members of individuals who receive services and supports funded by Vaya. The CFAC is a self-governing committee that helps ensure Vaya members and recipients are involved in Vaya's oversight, planning, and operational committees. Under state law, CFAC is responsible for the following functions:

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

The CFAC meets at least six times per year and fulfills the composition requirements of N.C.G.S. § 122C-170, with members representing all counties in Vaya's service area, as well as individuals with mental health, substance use disorder, I/DD, and/or TBI needs. The CFAC maintains regional sub-groups that facilitate local planning for members/ recipients and families, as well as cross-regional planning and implementation.

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

LTSS MEMBER ADVISORY COMMITTEE

The LTSS Member Advisory Committee garners stakeholder input and advice regarding LTSS covered under the Tailored Plan contract and meets all provisions noted in 42 C.F.R. § 438.110. Committee membership reflects the LTSS populations served by Vaya, and the committee receives reports from Vaya that enable it to review member experience and quality of care to serve as an early warning system for Vaya on any emerging issues. Vaya consults with the LTSS Member Advisory Committee on at least a quarterly basis.

HUMAN RIGHTS COMMITTEE

The Human Rights Committee (HRC) is a subcommittee of the Board of Directors and is responsible for monitoring Vaya's compliance with federal and state laws, rules, and regulations regarding client rights and confidentiality; ensuring implementation of the Cultural Competency Plan and related issues; and reviewing and monitoring trends related to restrictive interventions, abuse, neglect, and exploitation, as well as member/recipient 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 Vaya's CMO, other expert advisors, and community stakeholders. The HRC meets at least quarterly and reports to the Board of Directors, which is ultimately responsible for the assurance of member/recipient rights.

Provider Advisory Council

As a network provider, you are encouraged to participate in Vaya's Provider Advisory Council (PAC), which serves as an advisory body to Vaya on issues affecting network providers. The PAC operates pursuant to a set of bylaws and is a self-governing committee. Its membership reflects a broad cross-section of Vaya network provider types, available services, and disability groups served.

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

1. Fostering partnerships with Vaya to address issues affecting the behavioral health and I/DD public service system
2. Recommending and supporting the provision of best practices to empower members/recipients within Vaya's region to achieve their personal goals
3. Fostering communication and collaboration between network providers to improve member/recipient care

4. Providing input and recommendations to Vaya about clinical and provider payment policies, selection and retention criteria, dispute resolution mechanisms, the Provider Operations Manual, and other guidelines and requirements that directly impact network providers
5. Assisting in the dissemination of statewide Provider Satisfaction and Member Perception of Care surveys, providing input in the development of Vaya surveys and making recommendations to improve survey participation and the perception of care in the community
6. Reviewing the results of surveys and the annual Network Adequacy and Accessibility Analysis, advising Vaya in continued network development, and developing and making recommendations for service delivery models and gaps in services
7. Addressing strategies regarding funding and financial issues and providing feedback about network development initiatives, funding priorities and opportunities, as well as requests for proposal (RFPs), requests for information (RFIs), and other procurement initiatives
8. Assisting in the development of global and individual provider performance outcomes, making recommendations for network quality management practices, and advising Vaya on service trends, quality improvement plans, utilization and performance measures, and provider quality and outcome indicators
9. Providing feedback to Vaya about provider and community education, technical assistance, and training needs
10. Identifying members to participate in designated Vaya committees and PAC subcommittees that address initiatives such as quality improvement, clinical practices, finance/claims, integrated care, training, bylaws, ethics, cultural competency, network development, claims processing, and this manual

Code of Ethics

Vaya expects all employees, agents, contracted providers, vendors, and delegated subcontractors we work with to practice honesty, directness, and integrity in dealings with one another, business partners, the public, the business community, internal and external stakeholders, members/recipients, suppliers, elected officials, and government authorities. To further this requirement, the PAC developed a Code of Ethics that is incorporated into this manual as Appendix D. 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 to Vaya for investigation and potential adverse action.

Stakeholder and Community Involvement

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

Vaya also maintains collaborative working relationships with a variety of community stakeholder and human service agencies within the region to assess what services are working or needed and to ensure integration of care to support members/recipients who are involved with multiple agencies. These organizations include DSS agencies, local health departments (LHDs), Federally Qualified Health Centers (FQHCs), community hospitals and regional health systems, public schools, law enforcement, courts, Juvenile Court counselors, the National Alliance

on Mental Illness (NAMI), Community Care of North Carolina (CCNC), Area Health Education Centers (including the Mountain Area Health Education Center, known as MAHEC, and the Northwest Area Health Education Center, known as NW AHEC), primary care providers (PCPs), and Clinically Integrated Networks (CINs).

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

Provider Communications and Technical Assistance

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

Vaya requires all network providers to remain up to date on relevant information and changes communicated by NC Medicaid and the NC Division of Mental Health, Developmental Disabilities, and Substance Use Services (Division of MHDDSUS) through the following links on the NCDHHS website:

- NC Medicaid Bulletins
- Joint NC Medicaid (DHB) and Division of MHDDSUS Communication Bulletins (note: Joint Communication Bulletins supersede the previous joint NC Medicaid and Division of MHDDSUS Implementation Updates and the previous Division of MHDDSUS Communication Bulletins)
- NC Medicaid Clinical Coverage Policies

Vaya also provides technical assistance related to requirements of the Vaya provider agreement, this manual, NCDHHS, and other oversight authorities. Topics may include authorization processes, claims, billing and reimbursement, development of appropriate clinical services, and quality improvement initiatives. We can also link you to national or state resources for technical assistance. However, Vaya does not offer technical assistance on issues that are generally considered standard operational activities in the health care industry, and we are not able to provide repeated technical assistance to network providers who have demonstrated they are unable to assimilate previous help.

Vaya maintains a dedicated provider-focused website that includes helpful information specifically targeted to network providers. Additionally, Vaya disseminates critical and/or time-sensitive information, including changes in policy or requirements that impact network providers, through official Vaya Provider Communication Bulletins. The Provider Communication Bulletin is delivered free of charge by email through Constant Contact. All network providers are required to subscribe to Vaya Provider Communication Bulletins and adhere to any changes communicated in these bulletins as of the effective dates indicated.

Please ensure you are signed up to receive Provider Communication Bulletins. We strive to keep our communications meaningful, targeted, and on point to avoid "information overload." However, failing to read Vaya Provider Communication Bulletins is not a valid excuse for non-compliance with requirements. Network

providers are required to be aware of changes that affect delivery of publicly funded services by taking actions such as:

- Reading all written communications sent to you by Vaya
- Keeping apprised of current information regarding service provision through communication bulletins published by Vaya, NCDHHS, NC Medicaid, and the Division of MHDDSUS
- Regularly reviewing the Vaya, NCDHHS, NC Medicaid, and Division of MHDDSUS websites for updates
- Ensuring employees and contractors are informed of new and/or changing information related to their functions
- Joining national and state provider advocacy organizations to learn more about best practices
- Attending Vaya's governing Board of Directors, Regional Board, HRC, CFAC, Innovations Stakeholders, or LTSS Member Advisory Committee meetings
- Participating in PAC meetings and other provider forums hosted by Vaya to learn from and about other network providers and share suggestions and guidance on improving the system of care
- Participating in provider trainings offered by Vaya, NCDHHS, and other organizations
- Inviting Vaya staff to meet with you, your staff, or your governing board as needed to clarify issues or provide technical assistance

Provider Portal

Vaya's Provider Portal, accessible at https://providers.vayahealth.com/provider-portal/, allows providers to submit claims manually, view and manage all claims (including claims submitted outside the portal, such as EDI claims), view payment information associated with a claim, submit service authorization requests (SARs), view and manage all authorizations, submit recipient enrollment requests, and submit requests to update a recipient's information. In addition, providers can view and download this manual, access training materials, and submit both grievances and appeals through either the Provider Portal or an external system linked from the Provider Portal.

The Provider Portal is the primary mechanism for sharing data with providers, including:

- Administrative, clinical, and claims/encounter data
- Quality measurement information
- Cost measurement information

For more information, call the Provider Support Service Line at 1-866-990-9712 or email provider.info@vayahealth.com. Our goal is to respond to all inquiries within one business day.

2

SECTION 2
Clinical Practice Standards

Physician-Directed Treatment Services

Vaya values the role of physician leadership in the provision of medically necessary and medically directed services. This section of the manual, developed by our Chief Medical Officer in consultation with our Clinical Advisory Committee, outlines Vaya's requirements for services that require physician oversight. Vaya's Quality Management Department periodically validates adherence to these requirements, including during investigations prompted by complaints from members/recipients and families.

PHYSICIAN TEAM LEADERSHIP AND ON-SITE SERVICES

Medically necessary services for physician-directed levels of care such as inpatient, Facility-based Crisis (FBC), Assertive Community Treatment (ACT), and Psychiatric Residential Treatment Facility (PRTF) require clinical oversight and direct participation with the treatment team. This cannot be managed primarily through use of telemedicine, unless specific waivers are authorized by Vaya (such as in response to service delivery challenges related to a state of emergency resulting from a pandemic or natural disaster).

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

Schedule II Medications

Physicians must comply with applicable state and federal laws, rules, and regulations, as well as the policy of the North Carolina Medical Board, for the use of Schedule II medications. This includes checking the NC Controlled Substances Reporting System (directly or through delegation) when prescribing Schedule II medications and being cognizant of potential medication misuse or diversion.

Comprehensive psychiatric care includes competencies in serving all disability groups with various comorbidities and requires effective communication and collaboration with all health care providers involved with each individual. Comprehensive psychiatric care includes use of appropriate medications based on best practice principles after completion of a thorough history, record review, and clinical exam. Appropriate medications may

include stimulants, benzodiazepines, and opiates. It is not acceptable for Vaya providers to adopt or implement a policy of advising members/recipients that Schedule II medicines are never prescribed.

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

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

Physician Supervision of Mid-Level Prescribers

Mid-level practitioners provide key services to Vaya members/recipients. Current North Carolina licensure requires use of collaborative practice agreements (CPAs), which define both scope of practice and required supervision and consultation. While Schedule II medications can provide life-saving treatment, they can also significantly increase risk of adverse outcomes. Vaya recommends the CPA specifically address what consultation is required between the physician and mid-level prescriber for Schedule II medications, with delineation of required documentation of discussion and review of risk/benefit issues for members/recipients who:

- Are not in recovery from their substance use disorder;
- Have a history of psychosis;
- Have a history of aggressive behavior, domestic violence, or criminal involvement; and/or
- Are on three or more maintenance antipsychotic medications.

Community Safety/Population Health

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

3

SECTION 3
Benefit Plans, Covered Services, and Utilization Management

Vaya Benefit Plans

Vaya's benefit plans include both Medicaid and State-funded (non-Medicaid) services. For more information, visit our Provider Central website at providers.vayahealth.com.

NC MEDICAID BEHAVIORAL HEALTH AND I/DD TAILORED PLAN

Vaya's NC Medicaid Behavioral Health and I/DD Tailored Plan, called Vaya Total Care, includes all health services required by the NC Medicaid 1115 Demonstration Waiver and the North Carolina Medicaid State Plan. Available Tailored Plan Medicaid services include physical and behavioral health care, pharmacy benefits, I/DD services, TBI services, and LTSS under one plan.

Vaya Total Care serves Medicaid beneficiaries who have intensive, specialized behavioral health, I/DD, or TBI needs. Our plan is designed to make decisions easier, improve outcomes, and help members achieve better overall health and well-being through one plan and one point of contact. Please refer to Appendix A for covered services and associated clinical coverage policies.

NC INNOVATIONS/1915(C) WAIVER SERVICES

The Vaya Tailored Plan includes services available through NC Innovations, a 1915(c) HCBS waiver. Vaya's Innovations Waiver benefit package includes all services required by the Waiver and NC Medicaid Clinical Coverage Policy No. 8P. For more information, see Section 18 of this manual.

1915(i) STATE PLAN AMENDMENT SERVICES

The Vaya Tailored Plan includes 1915(i) HCBS for eligible members. For more information, visit our Provider Central website.

TAILORED PLAN STATE-FUNDED SERVICES

The Vaya Tailored Plan includes State-funded (non-Medicaid) behavioral health, I/DD, and TBI services made available through State single stream funding, federal block grants, and county dollars. The State-funded services managed by Vaya act as a public safety net. Vaya is committed to ensuring resources benefit the people who need it most. Vaya targets State funding toward services for individuals 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 health disorders, emotional disturbances, and substance use disorders with key complicating life circumstances, conditions, and/or situations.

State-funded services are not an entitlement. Vaya can fund services under this benefit plan only within the resources allocated to us. Other than crisis or emergency services, State-funded services are generally not available to undocumented individuals. Residential treatment is generally not covered under the State-funded 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.

Please refer to Appendix B for a list of covered State-funded behavioral health, I/DD, and TBI services. Our State-funded benefit plan is available on our Provider Central website.

NC MEDICAID DIRECT PREPAID INPATIENT HEALTH PLAN (PIHP)

Vaya manages certain services for Medicaid beneficiaries who are not enrolled in NC Medicaid Managed Care. Our NC Medicaid Direct PIHP includes behavioral health, I/DD, and TBI services. NCDHHS manages physical health services, pharmacy benefits, LTSS, and non-emergency medical transportation for Vaya's NC Medicaid Direct members.

Pharmacy

Pharmaceutical management is an integral part of whole-person care. Vaya's pharmacy program ensures access to clinically appropriate agents at the appropriate site of care. We encourage prescribers to review and consider the following guidelines:

- National standards of care guidelines for treating conditions (e.g., American Diabetes Association [ADA] Standards of Medical Care in Diabetes, Global Initiative for Chronic Obstructive Lung Disease [GOLD] guidelines, American Psychiatric Association Clinical Practice Guidelines)
- The NCDHHS Preferred Drug List (PDL)

Additionally, prescribers are encouraged to prescribe generic medications when therapeutically equivalent drugs are available within the drug class. Information about Vaya's pharmacy benefits may be found on our website. This location includes information for providers and members about:

- The formulary;
- UM Policy, including pharmacy clinical coverage and prior authorization (PA) criteria;
- PA request form(s); and
- Information about how to access medication during a disaster or emergency.

PREFERRED DRUG LIST (PDL)

Vaya has adopted the NC Medicaid PDL. The PDL provides a list of all preferred and non-preferred medications in drug classes managed by NC Medicaid. Some therapeutic classes are not managed by NC Medicaid and therefore not included on the PDL. These medications are covered and considered preferred unless explicitly excluded from coverage by state or federal law.

The NC Medicaid PDL is a published prescribing reference of prescription drug products selected by the NC Medicaid PDL Review Panel and approved by the NC Medicaid Pharmacy and Therapeutics (P&T) committee. All NC Medicaid Managed Care plans, including the Vaya Tailored Plan, provide coverage for all prescription drugs listed in the PDL. Medications are selected based on their efficacy data, safety profile, published clinical literature, and cost-effectiveness.

To request exceptions to the PDL with member-specific clinical justification, providers should call the Pharmacy Service Line (1-800-540-6083) or complete the Formulary Exceptions Form available in the Vaya Provider Portal.

The NC Medicaid PDL Review Panel meets at least annually to review current coverage, consider new-to-market medications, and evaluate PDL recommendations from the public. Requests to add or change the NC Medicaid PDL can be submitted to NCDHHS or to Vaya's Pharmacy Director of North Carolina Medicaid Managed Care Program for consideration. Additionally, providers and community members may request to speak at a PDL Review Panel Meeting by emailing Medicaid.PDLReviewMeeting@dhhs.nc.gov. Please note that this email address is only active during the 45-day period before PDL Review Panel meetings. If there are changes to the PDL and other formulary medications, Vaya will:

- Include updates in the Provider Communication Bulletin;
- Post updates to the Vaya website; and
- Send member-specific communication to the provider if a formulary change directly impacts the member's care.

GENERIC MEDICATIONS

Generic medications offer equal efficacy and safety while generally costing less than brand name equivalents. Use of generic medication is critical to the cost-effective, sustainable, whole-person care managed by Vaya and NC Medicaid.

Generic medications must be dispensed when available and on the PDL. Occasionally, the NC Medicaid PDL Review Panel may prefer a brand name medication over an available generic to obtain the lowest net price. In these instances, pharmacies must dispense the brand name product.

COVERAGE LIMITATIONS

Vaya's Tailored Plan for Medicaid members covers all therapeutic classes of drugs available through NC Medicaid Direct, the North Carolina fee-for-service Medicaid program. Certain therapeutic classes are excluded from coverage due to state and federal rules. Non-covered products include, but are not limited to, the following (see NC Medicaid Clinical Coverage Policy (CCP) Nos. 9, 9A, 9B, 9D, and 9E for details):

- Products that are experimental, investigational, or part of a clinical trial
- Over-the-counter (OTC) drugs, except as included on the PDL and in CCP 9A – Over-the-Counter Products
- Products prescribed primarily for the convenience of the member, caregiver, or prescriber
- Products that duplicate the therapeutic purpose of other therapy the member is receiving
- Products that have not been determined to be safe and effective by the U.S. Food and Drug Administration (FDA) (e.g., Drug Efficacy Study Implementation [DESI] drugs)
- Products being used for a purely cosmetic reason
- Drug samples or prescriptions being covered by a manufacturer's patient assistance program

- Prescription-only vitamins, minerals, and supplements
- Fertility drugs
- Drugs to treat erectile dysfunction
- Products to promote weight loss or weight gain
- Cough/cold products that contain an expectorant or cough suppressant

MEDICATION-SPECIFIC LIMITS

The NC Medicaid P&T Committee may impose medication-specific limits to optimize medication safety and promote cost-effective care. Please note:

- Prior authorization or coverage determination reviews ensure appropriate use of select preferred and non-preferred medications. Medications requiring prior authorization typically are high-risk, have a high potential for misuse, or are high-cost.
- Step therapy programs ensure an adequate trial of a safe, cost-effective therapy is attempted before using a more expensive option. The NC Medicaid P&T Committee has evaluated first-line preferred medications and considers them to be safe, effective, and economical.
- Quantity limits ensure medications are used in a manner consistent with FDA-approved dosing guidelines. Quantity limits also help prevent billing errors.
- Age limits ensure safety consistent with FDA-approved dosing guidelines.

Prescribers may request exceptions to medication-specific limits with member-specific clinical justification by calling the Pharmacy Service Line (1-800-540-6083) or completing the Medical Exceptions Form available in the Provider Portal. A Clinical Pharmacy Team conducts initial coverage determination reviews. Vaya's policy is to complete initial coverage determination reviews within 24 hours of receiving all necessary information.

To request an appeal of an adverse benefit determination, prescribers must call the Pharmacy Service Line (1-800-540-6083) or submit the appeal request form available in the Provider Portal. Vaya's policy is to complete all appeal reviews no later than 30 days after the appeal is received. Prescribers may request an expedited appeal when an adverse benefit determination could jeopardize a member's health or safety. Expedited appeals are resolved no later than 72 hours after receipt of the completed request.

INJECTABLE AND INFUSION SERVICES

The NC Medicaid Physician Administered Drug Program (PADP) covers drugs purchased for use in an outpatient setting under the pharmacy benefit with no prior authorization requirement. A list of medications covered under the PADP and the corresponding fee scheduled is available on the NCDHHS website.

Many injectable and infusion medications are also available through the Outpatient Pharmacy Program. Use of outpatient pharmacies can help prescribers avoid drug product storage, inventory management, and record maintenance issues. In addition, products dispensed by outpatient pharmacies are subject to a robust set of utilization review edits before the claim is paid. Types of edits include drug/drug interactions, drug/disease interactions, incorrect dose or duration of treatment, therapeutic duplication, drug/allergy interactions, and clinical abuse/misuse. Prescriptions dispensed through the Outpatient Pharmacy Program are included in the automated utilization review of other medications, contributing to a more complete and consolidated medication profile.

Select injectable and infusion medications are only available through an outpatient pharmacy and require prior authorization. For more information about medication coverage or prior authorization, contact the Pharmacy Service Line at 1-800-540-6083. If you are having difficulty accessing medication to administer to a Vaya member, the Pharmacy Service Line may be able to connect you to an in-network pharmacy capable of helping procure medication.

To access the list of medications requiring prior authorization, prior authorization forms, and clinical coverage policies, visit the NC Medicaid Clinical Coverage Policies webpage.

VAYA HEALTH LOCK-IN PROGRAM

Vaya encourages the safe prescribing, dispensing, and use of controlled substances. Vaya leverages medical and prescription claims data to identify members at high risk of prescription opioid and benzodiazepine misuse, abuse, or harm. The Vaya Health Lock-in Program aims to engage members in harm reduction behaviors to improve quality of care, increase safety, and reduce inappropriate service utilization.

Members identified as overutilizing drugs in these therapeutic classes may be placed in the Vaya Health Lock-in Program. Members in this program are restricted to receiving opioid and benzodiazepine prescriptions from up to two providers (e.g., pain management and behavioral health) and up to two pharmacies to obtain their opioid and benzodiazepine prescriptions. Claims submitted by other prescribers or other pharmacies will not be paid. Prescribers or pharmacies can request exceptions, subject to limits, for emergency situations by calling the Pharmacy Service Line at 1-800-540-6083.

Durable Medical Equipment

Durable medical equipment (DME) is primarily and customarily used to serve a medical purpose and is generally not useful to an individual in the absence of a disability, illness, or injury. DME can withstand repeated use and can be reusable or removable. Categories of DME and medical supplies are:

1. Inexpensive or routinely purchased items
2. Capped rental/purchased equipment
3. Equipment requiring frequent and substantial servicing
4. Oxygen and oxygen equipment
5. Related medical supplies
6. Service and repair
7. Other individually priced items
8. Enteral nutrition equipment

NC Medicaid covers DME when it is medically necessary and meets the following criteria:

1. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the member's needs;
2. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
3. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, caretaker, or provider.

DME and related medical supplies must also meet ALL the following requirements to be covered:

- The item is ordered by a physician, physician assistant, or nurse practitioner;
- The item is medically necessary to maintain or improve a member's medical, physical, or functional level and appropriate for use in any non-institutional setting in which normal life activities take place;
- Documented, face-to-face encounter between the member and ordering physician, physician assistant, or nurse practitioner related to the primary reason the member requires DME and medical supplies has occurred no more than six months prior to the initiation of request for DME and medical supplies; and
- The member's need for DME and medical supplies is reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

DME UTILIZATION MANAGEMENT

Prescribers must document medical necessity for every item provided, regardless of any approval requirements. A letter of medical necessity, written and signed by the physician, physician assistant, nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their North Carolina state licensing board, must be submitted along with the Certificate of Medical Necessity/Prior Approval (CMN/PA). Providers may not deliver an item requiring prior approval before receiving approval.

Providers must be alert to changes in the member's needs for rental items and supplies and work with the physician, physician assistant, or nurse practitioner to implement the changes. At a minimum, the continuing need to provide a rental item (one that is not subject to prior approval) or a supply must be verified with the attending physician, physician assistant, or nurse practitioner at least every 12 months. If there is a need for one of these items beyond 12 months from the date of last signed CMN/PA, a new CMN/PA must be completed and signed by the physician, physician assistant, or nurse practitioner for continued coverage. The provider must obtain the signed form before billing for any services beyond 12 months.

DME PROVIDER REQUIREMENTS

Providers must be enrolled with NC Medicaid as a DME and supplies provider and meet the following conditions:

- Providers cannot accept prescriptions for Medicaid-covered equipment from any physician, physician assistant, or nurse practitioner who has an ownership interest in their agency.
- Providers must be enrolled and participate in Medicare as a medical equipment supplier.
- The service must be provided on an emergency basis, 24 hours per day, seven days per week, for life-sustaining equipment.
- The providing agency must be located in North Carolina or within 40 miles of the North Carolina border in a contiguous state from which North Carolina members living near the border can use the agency as a general practice.
- Refer to the NC Board of Pharmacy website (under the topics "DME Suppliers" and "Pharmacy Law/Rules") for other rules that may apply to DME and supplies providers.
- Providers must be a business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization must include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit, or privilege license; or a Medicaid-enrolled home health agency, a state agency, an LHD, a local lead agency for the Community Alternatives Program for Disabled Adults (CAP/DA), or an agency that provides case management for the Community Alternatives Program for Children (CAP/C).

Vaya will contract with DME providers/vendors to meet DME needs based on the statewide, NCDHHS-approved DME list. The network will remain open to ensure network adequacy based on time and distance standards. Vaya will accept single-case agreements when the requested DME is medically necessary and cannot be provided by a network provider.

DME PROOF OF DELIVERY

Each member will receive a survey to confirm delivery and set-up.

DME DOCUMENTATION

Providers must keep the following documentation of their services:

- The prescription for the item signed by the physician, physician assistant, or nurse practitioner specifying the order (such as the quantity ordered, frequency of use, and duration of prescription)
- The original CMN/PA form for DME and supplies
- The original orders signed by the physician, physician assistant, or nurse practitioner that were used to provide enteral nutrition
- A full description of all items supplied to a member
- The dates the items were supplied, including the delivery date for purchased items or the delivery/pickup dates for rental items and signed pick-up and delivery slips (the delivery slip must be signed by the member or their designee when the delivery is direct to the member)
- A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair (if the item is removed from the member's environment for service or repair, the record must include the date of removal and the date of return)

DME MONITORING

Vaya's Quality Management Department and the Special Investigations Unit (SIU) monitor DME providers. Information gathered during any monitoring process that suggests misuse of public funds or fraud, waste, or abuse will be referred to the SIU. Vaya may also make a referral to another agency, such as the North Carolina Board of Pharmacy, depending on the nature of the grievance and/or complaint. Please refer to Section 5 (Provider Responsibilities), Section 13 (Performance Improvement Procedures), Section 14 (Member and Recipient Rights and Empowerment), and Section 16 (Provider Program Integrity Requirements) of this manual for detailed information about monitoring. For additional information, refer to the NCDHHS DME webpage or the CMS Final Rule at 42 CFR § 440.70.

Personal Care Services

Eligible Vaya Tailored Plan members may qualify for Personal Care Services (PCS) based on their need for assistance with Activities of Daily Living (ADLs). ADLs include bathing, dressing, toileting, eating, and transferring/ functional mobility in the home. An independent assessment must be conducted to determine PCS program eligibility. To request a PCS Independent Assessment (e.g., new request, change of status, change of provider, or disenrollment), providers must complete and submit the Request for Independent Assessment for Personal Care Services: Attestation of Medical Need Form which is available on Vaya's Provider Central website.

Any Vaya Tailored Plan Medicaid member referred to or seeking admission to an Adult Care Home (ACH) licensed under N.C.G.S. § 131D-2.4 must be referred to a Tailored Plan for the Referral Screening Verification Process

(RSVP). ACH providers licensed under N.C.G.S. § 131D-2.4 shall not receive a PCS assessment or prior approval without verification of a Referral Screening Identification (RSID). If you have questions about your status in this process, contact Vaya's Diversion RSVP Manager at 1-800-893-6246, ext. 6564. For additional information, contact the Vaya Independent Assessment Team at 1-877-290-6315.

Prior Authorization Requirements

Vaya has a Utilization Management (UM) program for physical health, BH, I/DD, LTSS, and pharmacy services that is based on nationally recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies. **The Vaya UM Program Policy, including referral and prior authorization processes, is available on our website.**

Please note that not all Vaya-managed services require prior authorization. **Vaya does not require prior authorization for any pharmacy or physical health service that does not require prior approval per NC Medicaid clinical coverage policies**, available on the NC Medicaid Clinical Coverage Policies webpage.

For prior authorization requirements for behavioral health, I/DD, and TBI services, visit the Authorization Guidelines page of our Provider Central website.

Practitioners may freely communicate with members/recipients about their treatment, regardless of benefit coverage limitations. 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 or recipient.

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. A provider may not request authorization on behalf of another provider. Vaya can only process a complete, valid request. If the service authorization request (SAR) is not completed fully, including all required administrative and clinical information, it may be returned, delayed, or denied. Before requesting authorization for behavioral health, I/DD, or TBI services, the first step is to complete a Comprehensive Clinical Assessment (CCA) addressing the elements required by the applicable NC Medicaid Clinical Coverage Policy.

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 individuals we serve. Note that behavioral health clinical home (BHCH) providers generate and submit an individual's service plan for all behavioral health, I/DD, and TBI services but may request authorization for only those services that they provide.

HOW DO I COMPLETE AND SUBMIT A 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, include the name of the individual who is providing the service or who is most knowledgeable about the case and that person's telephone number at the end of the Justification for Service Request field.
- With limited exceptions, SARs must be submitted electronically via the Provider Portal. Please note that SARs for specific medical services may be reviewed by a delegated subcontractor. The Provider Portal contains instructions and/or a link to submit the request directly to the delegated subcontractor. In documented instances where electronic transmittal is not possible, Vaya may accept "paper" SARs via facsimile, U.S. mail, or hand-delivery. Providers are responsible for maintaining documentation showing the date the request was submitted. "Paper" SAR forms are available on the Prior Authorization page of our Provider Central website.
- **Network providers can request specific technical assistance about SAR submission by contacting Vaya's Utilization Management (UM) Team at um@vayahealth.com or 1-800-893-6246, ext. 1513.**

WHEN DO I SUBMIT A SAR?

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

WHEN DOES VAYA RETURN A SAR AS UNABLE TO PROCESS?

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

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

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

- The request is an identical or duplicate, i.e., the provider submits two requests for the same service/same dates for a member/recipient OR two different providers submit the same request for the same member/recipient, in which case Vaya will process the first request received and return the second request as unable to process
- The member/recipient is not enrolled in a Vaya health plan.
- The request/supporting documentation contains inconsistent or conflicting information (e.g., name and Medicaid Identification Number do not match).
- The diagnosis or service is not covered by the applicable benefit plan.
- Funding is not available for a State-funded or 1915(i) Waiver service.
- The service does not require prior authorization.

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

SUPPORTING DOCUMENTATION

Providers are responsible for understanding what documentation is required to be submitted with a SAR. This information can be found in the applicable Medicaid waiver, applicable NC Medicaid CCPs, Division of MHDDSAS service definitions, and other references on the authorization section of our Provider Central website. Requests that are missing required information may result in an administrative denial, which means there is no clinical review, but the member/recipient receives a notice with appeal rights.

In addition to required documentation, Vaya strongly encourages providers to submit all information that will support a finding of medical necessity. We will consider all relevant information that is submitted. **Our experience is that providers sometimes wait to submit required or helpful supporting information until after a denial is issued. This delays care for members/recipients and creates more work for providers.**

SERVICE PLANS

Some behavioral health, I/DD, and TBI services require the development and submission of a service plan. Approved plan formats include the person-centered plan and care plan, also referred to as an Individual Support Plan (ISP), used with Innovations Waiver participants. For members/recipients receiving behavioral health services, plans must be submitted by the BHCH provider.

If a member/recipient does not have a BHCH, the provider must collaborate with other providers in developing the service plan. For Innovations Waiver participants, the plan is submitted for approval by the assigned care manager. 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/recipient'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/recipient or service being requested:

- *Either* the Early Childhood Services Intensity Instrument (ECSII), a comprehensive, strength-based, individualized, and coordinated service/treatment planning tool, or the Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers, a comprehensive, trauma-informed behavioral health evaluation tool
- NC Support Needs Assessment Profile (NC-SNAP), a needs assessment tool that measures an individual's level of intensity of need for I/DD supports and services. The NC-SNAP was developed by NCDHHS 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 Supports Intensity Scale® (SIS).
- The SIS is a tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) that measures the individual's support needs in personal, work-related, and social activities to identify and describe the types and intensity of the supports an individual requires. The SIS was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. All Vaya SIS assessors are trained by AAIDD in administration of the SIS. For more information, please see Section 4 of this manual or the AAIDD website.
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC), the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of individuals with substance use disorders and co-occurring conditions. For more information, visit the ASAM website.

INITIAL REVIEW PROCESS

UM staff review all initial authorization requests and, if the request is valid and able to be processed, determine if the request contains all required information. If information is missing, Vaya either contacts the provider to request more information or issues an administrative denial. Administrative denials are not reviewed for medical necessity but contain appeal rights. **"Unable to process" and administrative denials must not exceed 10 percent of your monthly SAR submissions.**

Providers have up to three business days to submit any requested additional information.

If the request contains all required information, we then determine if medical necessity criteria are met. All requests for Medicaid members under age 21 are also reviewed against Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria. Vaya will never ask a provider to withdraw or modify a request. However, the provider may withdraw or modify a request at any time if they decide a different service would be more clinically appropriate.

If Vaya determines the request meets medical necessity and/or EPSDT criteria, we will approve the SAR, resulting in generation of an electronic authorization letter, available in Vaya's Provider Portal for your review. Please visit our Provider Central website or contact the Vaya Service Desk for help accessing authorization information. The authorization contains provider and member/recipient identification, authorization/tracking numbers, the name and total number of units of the service authorized, and authorization effective dates. The provider is responsible for notifying the member/recipient when a service is approved. We do not send notifications to members/recipients unless the request is denied (in whole or in part). **Note that authorization does not**

guarantee payment. Payment by Vaya is subject to other requirements and limitations set forth in your contract, this manual, and any other guidance or manuals published by Vaya.

PEER REVIEW

Behavioral health, I/DD, and TBI service requests that a Vaya clinician or nurse is unable to approve based on medical necessity or EPSDT are referred to a licensed, doctoral-level psychologist or physician for peer review. If Vaya is unable to approve a physical health service request, the UM reviewer refers the request to a physician for peer review. Peer reviewers review the SAR and all related submitted information to determine medical necessity. Additionally, the peer reviewer may contact the provider to obtain additional information or to better understand the information submitted.

The peer reviewer will identify themselves as calling on behalf of Vaya to discuss an authorization request for a specific individual. If the peer reviewer is unable to make contact on the first attempt, they may try again later. However, due to tight turnaround time requirements for authorization decisions, the peer reviewer will decide based on the information submitted with the SAR if they are unable to make contact or do not think a peer-to-peer conversation is necessary.

If Vaya issues a medical necessity denial without having conducted a peer-to-peer discussion, the provider may request one within three business days of the denial notice. If the clinical peer reviewer who made the initial decision is not available, the provider will speak with another equivalent peer reviewer. This discussion is not an appeal of the adverse benefit determination. Rather, it provides an opportunity to discuss the decision and reasons for the denial. Based on the peer-to-peer discussion, the peer reviewer may decide to 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: Providers can request expedited review of a SAR if they believe the standard timeframe could seriously jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. If expedited review criteria are met, we must complete the expedited review within 72 hours of the request. We can extend the deadline up to 14 additional days under certain circumstances, but this generally does not occur as it defeats the purpose of an expedited review.
    - If we agree the request meets expedited criteria, we will notify you and/or the member/recipient by phone. We will send a written decision no more than three days after the phone notification.
    - If we do not agree expedited review is necessary, we will notify you and the member/recipient and process the request within 14 days. Denial of expedited review cannot be appealed, but you or the member/ recipient can file a grievance or complaint if you disagree with our decision.
- Inpatient hospitalization and FBC 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 the above timeframes apply regardless of whether the authorization request is prospective (the service not currently authorized for the individual), concurrent (the service is currently authorized for the member), or

retrospective (the service was already delivered, and the provider is seeking authorization to ensure reimbursement).

MEDICAL NECESSITY

Vaya uses medical necessity criteria when making authorization decisions. Under our contract with NC Medicaid, medical necessity for services is defined as treatment that is:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a behavioral health, I/DD, or medical condition;
- Consistent with Medicaid policies and national or evidence-based standards, NCDHHS-defined standards, or verified by independent clinical experts at the time the procedures, products, and the services are provided;
- Provided in the most cost-effective, least restrictive environment that is consistent with clinical standards of care;
- Not provided solely for the convenience of the member/recipient, their family, custodian, or provider;
- Not for experimental, investigational, unproven, or solely cosmetic purposes;
- 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 42 CFR, the Medicaid State Plan, the North Carolina Administrative Code, NC Medicaid CCPs, and other applicable federal and state directives;
- Sufficient in amount, duration, and scope to reasonably achieve its purpose; and
- Generally recognized as an acceptable treatment when paired with the reported diagnosis(es) regarding intensity, duration of service, and setting of treatment.

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

- Conform with any advanced medical directive prepared by the individual/legally responsible person (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 and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT is a part of the federal Medicaid law that requires state Medicaid programs to pay for regular screenings and certain services for children under age 21, even if the services are not included in the State Medicaid Plan or applicable Medicaid 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 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; and
- Must be safe and effective.

Vaya reviews all requests submitted for Medicaid services for children under age 21 against these criteria. Please remember that all prior authorization requirements also apply to EPSDT services. In addition to coverage of services not traditionally covered by Vaya, service coverage under EPSDT means that UM policy, applicable

Medicaid waiver, and NC Medicaid CCP limits on hours, units, and visits that apply to adults may not apply to children under age 21. However, the Innovations Waiver annual budget limit cannot be exceeded under EPSDT. To request services for a child under the EPSDT benefit, providers must submit the EPSDT Non-Covered Service Request Form available on our Provider Central website.

EPSDT claims do not follow the payor of last resort rules. Vaya pays these claims as primary and pursues any recovery from the liable third party.

Notices of Approval/Denial

The SAR review may result in a full approval, partial approval, or a full administrative or clinical denial. If we issue a partial approval or denial, the member/recipient receives a written notice that includes information about appeal rights and an Appeal Request Form. All written notices are sent via certified mail to the address on file in our system.

Members/recipients who move and fail to notify their county DSS office and/or Vaya may have difficulty receiving the notice and filing a timely appeal. Please help us ensure members/recipients know to keep their address current with DSS and/or Vaya and accept certified mail from Vaya. The effective date of the decision is the date the notice is mailed, except that if a service is terminated or reduced before the current authorization expires, the effective date will be no sooner than 10 days after the date the notice is mailed. Please note that adult Medicaid members cannot appeal the denial of any portion of services requested in excess of NC Medicaid policy/waiver limits.

Member and Recipient Appeal Process

Network providers are responsible for understanding and helping members/recipients with the appeal process. Vaya does not retaliate in any way against a member, recipient, or provider who requests an appeal or an expedited review. Appeal requests may be submitted using the contact information included on the adverse benefit determination notice or to Vaya in any of the following ways:

- **Phone:** 1-800-962-9003
- **Email:** member.appeals@vayahealth.com
- **Fax:** 1-833-845-5616
- **Mail:** Vaya Health, Attn: Member and Recipient Appeals, 200 Ridgefield Court, Suite 218, Asheville, NC 28806
- **In person:** Vaya's administrative offices, 200 Ridgefield Court, Suite 218, Asheville, NC 28806

For help, call the Member and Recipient Service Line at 1-800-962-9003 or the Vaya Member and Recipient Appeals Team at 1-800-893-6246, ext. 1400.

MEDICAID SERVICE APPEALS

Appeals of a Medicaid adverse benefit determination may be requested in writing or orally within 60 days of the notice. Members or LRPs who request appeal of orally do not need to follow up with a written request. All Notices of Adverse Benefit Determination (NABDs) sent to the member or LRP include an Appeal Request Form. Providers requesting an appeal of an NABD on behalf of a member may submit an oral or written request if the member or LRP provides written consent authorizing the provider to file the appeal on their behalf.

More detailed information about the appeal process is included in the Vaya Health Tailored Plan Member Handbook and Vaya Health NC Medicaid Direct Member Handbook available at vayahealth.com. It is very important for members to follow all procedures and timelines outlined in the notice. Members must go through the Vaya appeals process before filing a Medicaid appeal with the NC Office of Administrative Hearings (OAH).

Vaya sends an acknowledgement letter when we receive an appeal request unless an expedited reconsideration is requested and accepted. Vaya sends a Notice of Receipt of Appeal Request to the member or LRP within five days of receipt of a valid written or oral request. Appeal requests are reviewed by a health care professional with appropriate clinical expertise in treating the member's condition or disorder and who was not involved in the original decision and is not a direct subordinate of the initial decisionmaker. Members can request a copy of their records from Vaya, and Vaya will accept and consider new or additional information if received within the required appeal timeframes.

Vaya issues a written Notice of Decision within 30 days of receipt of a timely appeal. If a member disagrees Vaya's decision, they can file an appeal with OAH within 120 days of the date of the Vaya Notice of Decision. The Notice of Decision includes instructions to appeal to OAH and a State Fair Hearing Appeal Form.

Expedited Appeals

Vaya will expedite the review if we agree a member or LRP's request for an expedited review meets established criteria or if the ordering provider (or another qualified provider with knowledge of the member's medical condition) indicates the standard timeframe could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function. We will attempt to notify the member of our decision by phone and will notify both the provider and member in writing within 72 hours of the request for an expedited appeal.

If we determine an expedited review is not necessary, we will notify the provider and the member of our decision and process the request within the applicable timeframe. Vaya makes reasonable efforts to give members prompt oral notice of decisions and provides a written notice within two calendar days of the date we denied the request for an expedited appeal. The member or LRP may file a grievance of this decision, but they may not appeal the denial to expedite the request.

Vaya may extend the timeframe to issue a written decision (for either a standard or expedited appeal) by up to 14 calendar days if the member or LRP requests the extension or Vaya demonstrates that there is need for additional information and the delay is in the member's interest. We will make reasonable efforts to give the member prompt oral notice of the extension, with notification in writing within two calendar days. If a member or LRP disagrees with the extension, they have the right to file a grievance.

Continuation of Benefits

With the limited exception of 1915(i) services that may be terminated if a member is determined to no longer be eligible for 1915(i) services, there is no "maintenance of service" under NC Medicaid Managed Care or NC Medicaid Direct. However, if Vaya reduces, suspends, or terminates a previously authorized service, we will continue the service if all following conditions are met:

- Vaya receives a timely request for appeal;
- The member remains eligible for Medicaid;
- The services were ordered by an authorized provider;

- The authorization period for the services has not expired; and
- Vaya receives a timely request (meaning on or before the later of within 10 calendar days of the NABD or the intended effective date of Vaya's proposed decision) for the member's services to continue.

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

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

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

If NC DHHS' vendor determines that a member is no longer eligible to receive 1915(i) services and Vaya subsequently terminates existing authorizations for 1915(i) services, Vaya will continue to reimburse providers authorized to deliver the terminated 1915(i) service(s) under "maintenance of effort" if the member appeals the termination of his or her eligibility to receive 1915(i) services.

STATE-FUNDED SERVICE APPEALS

Recipients who wish to appeal an adverse decision regarding their State-funded services must submit a request to Vaya in writing within 15 business days of the notice of adverse decision. While we encourage providers to help recipients appeal an adverse decision, providers may not file the appeal on the recipient's behalf.

Vaya will issue a decision within seven business days of receipt of a timely request. If a recipient disagrees with our decision, they can file an appeal with the Division of MHDDSUS within 11 calendar days of the date of the notice. The notice includes instructions and an appeal form. Recipients must go through the Vaya appeals process before filing an appeal with the Division of MHDDSUS. Please note there is no "maintenance of service" for State-funded services.

Second Opinion

Medicaid members who disagree with their diagnosis, treatment, or prescribed medication have the right to a second opinion. Vaya informs members of this right in the Vaya Health Tailored Plan Member Handbook and the Vaya Health NC Medicaid Direct Member Handbook, as well as on the Vaya website. Providers must refer any member who requests a second opinion is to Vaya's Utilization Management Team.

Vaya Clinical Practice Guidelines

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

promulgated by a nationally recognized peer review organization, such as the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP).

Clinical practice guidelines are designed to guide providers on how to follow national and community standards of practice. Providers are expected to maintain or advance the quality of services through the demonstration of practice consistent with the adopted clinical practice guidelines and suggested best practices. Clinical practice guidelines are not a substitute for the advice of a health care professional or the utilization reviewer or peer reviewer making medical necessity determinations. Guidelines are available our Provider Central website. In addition, providers must adhere to NC Medicaid Clinical Coverage Policies.

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SECTION 4
Care Management

Vaya provides access to integrated Tailored Care Management (TCM) to eligible Tailored Plan Medicaid members and NC Medicaid Direct members who choose to participate. Members may receive TCM from a provider organization or from Vaya. TCM is a free benefit and is available to qualifying members continuously throughout their enrollment, regardless of geography, unless the member is receiving duplicative care management services as part of another service or program. TCM is provided as close as possible to where the member lives or receives care to improve health outcomes. It includes enrollment, assignment, outreach and engagement, assessment, care plan development, crisis plan development, care team formation, transitional and ongoing care management, and diversion. TCM is based on the federal health home structure, and the care management delivered must meet those requirements, which are available on the Medicaid Health Homes website. For TCM information and provider resources, including the NCDHHS TCM Provider Manual, visit the NCDHHS TCM webpage.

Care managers coordinate and provide referrals, information, and help obtaining and maintaining physical health, behavioral health, I/DD, LTSS, TBI, pharmacy, vision, and dental services, including those covered by either Vaya or NC Medicaid Direct. Care managers also coordinate and provide referrals, information, and help obtaining and maintaining State-funded services managed by Vaya.

As a provider of services for members receiving TCM, you should plan to collaborate with the care manager in the following activities:

- Coordinating social services provided by community and social providers to address a member's unmet health-related resource needs, such as stable housing or access to food
- Coordinating Medicare services for members dually eligible for Medicare and Medicaid
- Coordinating with other care management supports for members dually eligible for Medicare and Medicaid
- Ensuring members have annual physical exams or well-child visits based on the appropriate age-related frequency
- Conducting a care management comprehensive assessment at least every 12 months
- Continuously monitoring the member's progress toward goals identified in the person-centered plan or care plan through routine care team reviews and in-person and collateral contacts with the member and their supports, including family, and informal and formal caregivers, as appropriate
- Conducting medication management, facilitating regular medication reconciliation by the appropriate care team member, and supporting medication adherence
- Supporting the member's adherence to prescribed treatment regimens and wellness activities
- Communicating and consulting with other providers, the member and their supports, and the care team as appropriate (this may include DSS workers, court counselors, medical home staff, health navigators, or other individuals or agencies that help members achieve their overall health goals)

- Following up on referrals
- Facilitating timely communication across the care team, including case conferencing
- Coordinating with Vaya care coordination and/or institutional transition activities

TCM Staffing Requirements

SUPERVISING CARE MANAGERS

Supervising care managers overseeing care managers performing TCM for members with behavioral health disorders must meet both of the following minimum qualifications:

- Be a master's-level fully licensed clinical social worker (LCSW), fully licensed clinical mental health counselor (LCMHC), fully licensed psychological associate (LPA), fully licensed marriage and family therapist (LMFT), or licensed RN; and
- Have three years of experience providing care management, case management, or care coordination to the population being served.

Supervising care managers overseeing care managers performing TCM for members with an I/DD or TBI must meet one of the following minimum qualifications:

- A bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN, and five years of experience providing care management, case management, or care coordination to individuals with complex I/DD or TBI needs; or
- A master's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN, and three years of experience providing care management, case management, or care coordination to individuals with complex I/DD or TBI needs.

When a member is dually diagnosed with a behavioral health disorder and I/DD or TBI, the TCM provider must ensure the supervising care manager is qualified to oversee the member's care manager.

CARE MANAGERS

Care managers must have a minimum of a bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN, in addition to the following requirements:

- If serving members with behavioral health needs, the care manager must have two years of experience working directly with individuals with behavioral health disorders.
- If serving members with I/DD or TBI, the care manager must have two years of experience working directly with individuals with I/DD or TBI.
- If serving members with LTSS needs, the care manager must have a minimum of two years of experience with LTSS and/or HCBS coordination, care delivery monitoring, and care management. This experience may be concurrent with the two years of experience working directly with individuals with behavioral health disorders, I/DD, or TBI as described above.
- If the member is dually diagnosed with a behavioral health disorder and I/DD or TBI, the TCM provider determines the appropriate care manager assignment.

CARE MANAGER EXTENDERS

Care manager extenders may support care managers by performing certain delegated activities. When a care manager extender performs one of the functions listed below, it counts as a TCM contact if made by phone, video and audio, or in-person contact with the member:

- Performing general outreach, engagement, and follow-up with members
- Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation)
- Engaging in health promotion activities (as defined in the TCM Provider Manual) and knowledge-sharing
- Sharing information about the member's circumstances with the care manager and other care team members
- Providing and tracking referrals and providing information and help obtaining and maintaining community-based resources and social support services
- Participating in case conferences
- Supporting the care manager in assessing and addressing the member's unmet health-related resource needs

A care manager must be solely responsible for the following activities/functions:

- Completing the care management comprehensive assessment
- Developing the person-centered plan (with members with behavioral health needs) or care plan (for members with I/DD or TBI needs)
- Facilitating case conferences
- Ensuring medication monitoring and reconciliation take place
- Continually monitoring progress toward the goals in the member's person-centered plan or care plan
- Managing care transitions, including creating 90-day transition plans

Some care manager extenders may have limited experience working with individuals with significant behavioral health, I/DD, and TBI needs. A care manager must directly supervise extenders and ensure they perform only those functions within their training, scope, and abilities. Supervising care managers, care managers, and care manager extenders should regularly communicate and coordinate efforts to mitigate duplicative or inappropriate member outreach.

Care manager extenders must:

- Be age 18 or older
- Have a high school diploma or equivalent
- Be trained in TCM
- Be supervised by a care manager
- Meet one of the following requirements:
    - Have lived experience with I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the NC Medicaid service delivery system;
    - Have lived experience with a behavioral health condition and be a certified peer support specialist;
    - Be a parent or guardian of an individual with an I/DD, TBI, or behavioral health condition and have at least two years of direct experience providing care for and navigating the Medicaid service delivery system on behalf of that individual (a parent/guardian cannot serve as an extender for their family member); or

- Have two years of paid experience performing the types of functions described in the "Extender Functions" section of the TCM Provider Manual, with at least one year of paid experience working directly with the TCM-eligible population.

A range of individuals may meet these qualifications, including:

- Certified peer support specialists
- Community health workers who have completed the NC Community Health Worker Standardized Core Competency Training (NC CHW SCCT)
- Individuals who worked as community navigators prior to the implementation of Tailored Plans
- Family navigators
- Parents or guardians of an individual with I/DD, TBI, or a behavioral health condition (the parent/guardian cannot serve as an extender for their own family member)
- A person with lived experience with an I/DD, TBI, or a behavioral health condition

CLINICAL CONSULTANTS

The assigned TCM provider must have access to clinical consultants to provide subject matter expert advice to the care team according to a member's specific health care and wellness needs. Clinical consultants are not required to be assigned to the care team for any given member. An Advanced Medical Home Plus (AMH+) or Care Management Agency (CMA) may employ or contract with consultants or work with a Clinically Integrated Network (CIN) or other partner to meet this requirement. Consultants should be available by phone within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis. The following consultants must be available:

- An adult psychiatrist or child and adolescent psychiatrist (depending on the population served)
- A neuropsychologist or psychologist
- A primary care provider (PCP) appropriate for the population served (to the extent the member's PCP is unavailable for consultation)

For information about provider-based TCM training, email provider.training@vayahealth.com.

Enrollment, Referral, and Assignment for TCM

ENROLLMENT AND ASSIGNMENT

All Tailored Plan and the NC Medicaid Direct members are "auto-enrolled" in TCM, except for individuals participating in the following services or programs, which duplicate care management:

- ACT
- ICF/IID services
- Care Management for At-Risk Children (CMARC)
- High-Fidelity Wraparound
- Care management through the NCDHHS Primary Care Case Management (PCCM) vendor
- Case management through the CAP/C and CAP/DA programs
- Nursing facility residential services, when the member has resided, or is likely to reside, in the facility for at least 90 calendar days

The following populations are prioritized for engagement into TCM:

- Members who are enrolled in both Medicare and Medicaid, and Medicaid coverage is not limited to coverage of Medicare premiums and cost-sharing;
- Members who are medically needy;
- Members who participate in the NC Medicaid Health Insurance Premium Payment Program; and
- Members who are currently or were formerly in foster care or are in the adoption assistance program.

Vaya accepts external referrals for TCM from members, relatives, and/or caregivers; community/social service agencies; practitioners, physical health and behavioral health providers and prescribers; medical management programs, such as disease management programs, UM programs, health information lines, or similar programs that can identify needs for care management; and discharge planners through the Department's Raise Your Hand process. Vaya expedites responses to referrals from medical providers, PCCM care managers, and state and local agencies, including DSS and NC Division of Juvenile Justice and Delinquency Prevention (DJJ) offices.

TCM is provided through one of the following three entities:

- **AMH+:** Only AMH Tier 3 practices certified as an AMH+ practice may provide TCM.
- **CMA:** At the time of certification, a CMA must have a primary purpose of delivering Medicaid or State-funded services (other than care management) to the Tailored Plan-eligible population in North Carolina.
- **Vaya:** Vaya provides plan-based TCM.

This process prioritizes community-based TCM over plan-based TCM. Vaya ensures all members, including Innovations Waiver participants, have a choice in their care management approach. As part of the TCM assignment process, Vaya considers a variety of member-specific factors, including:

- Member choice
- Existing relationship with a PCP practicing within an AMH+
- Existing relationship with a behavioral health provider practicing within a CMA or CMA-affiliated provider agency
- The complexity of the member's medical, behavioral health, I/DD, and/or TBI needs
- The member's geographic location and proximity to the TCM provider
- The mix of acuity levels at the potential assignment site (Vaya monitors TCM assignments to ensure AMH+s and CMAs do not select members for their panel based on acuity tier to avoid serving members at a certain acuity level)
- TCM provider capacity to serve particular disability categories and age groups at the potential assignment site (e.g., expertise and experience in working with subpopulations)
- Volume of engaged TCM participates at potential assignment site: Vaya assigns a sufficient volume of members to AMH+ and CMA sites to allow these organizations to substantially engage in the TCM model (i.e., achieve economies of scale in their TCM staffing); Vaya also permits AMH+s and CMAs to set limits on their panel sizes (i.e., to decline assignments based on capacity)
- To maintain automatic TCM assignment by Vaya, TCM providers must regularly inform Vaya of their capacity for accepting new members for TCM, including any limitations on capacity (e.g., only youth, only members with behavioral health diagnoses, up to 250 adults)
- Vaya assigns participants in the Innovations or TBI waivers to TCM providers who comply with federal requirements for conflict-free case management for 1915(c) waiver enrollees as outlined at 42 C.F.R. § 431.301(c)(1)(vi)

OUTREACH AND ENGAGEMENT

The assigned TCM provider must ensure the comprehensive assessment process begins within 30 days of the member's enrollment in a Vaya health plan. All TCM providers must have a documented process for informing members when they have been assigned to their organization. The care manager provides education about the benefits of TCM and answers questions about the TCM Enrollment Packet the member receives upon Tailored Plan enrollment. The outreach and engagement process may result in a member engaging in TCM, opting out of TCM, or being unable to be reached (UTR). Members who opt out of TCM or who are UTR are assigned to Vaya care coordination. Outreach methods incorporate telephonic, face-to-face, and written strategies. Care managers use motivational interviewing to help build trust and rapport with members to help maintain their engagement in TCM. The assigned care manager ensures the member has their contact information following initial contact.

TCM providers are required to develop and implement policies for communicating and sharing information with members (and their families and other caregivers, when applicable) with appropriate consideration for language, literacy, and cultural preferences, including use of American Sign Language, closed captioning, and/or video capture.

TCM providers are required to notify Vaya if assigned members are UTR or who opt out of TCM within five business days of the UTR or opt-out status determination. This allows Vaya's Member and Recipient Services Department to assign the member to Vaya care coordination to manage any care transitions.

Coordination with County Child Welfare Workers

TCM providers are required to establish specific coordination with county child welfare workers for members who are involved in the child welfare system and receive TCM. Care managers of members in foster care/participating in adoption assistance and former foster youth arrange an initial meeting with the member's assigned county child welfare worker (in person, by video, or by telephone). Initial meetings must occur within the following timeframes:

- For members enrolled upon initial plan launch, within 60 calendar days of launch or earlier, if necessary, to appropriately manage the member's health care needs; or
- For members enrolled after initial plan launch, within three calendar days, or earlier, if necessary, to appropriately manage the member's health care needs.

During the initial meeting, the care manager confirms the member has received or has been scheduled to receive the initial seven-day physical examination required by DSS and the 30-day comprehensive medical appointment. If the assessments have not been scheduled, the care manager works with the county child welfare worker to schedule the appropriate appointments. The care manager gathers, at a minimum, the following information:

- DSS Child Health Summary Components, to the extent available;
- Placement logs;
- The member's family history and foster care placement status;
- The member's immediate needs, including behavioral health and unmet health-related resource needs;
- The member's medication history;
- Child Maltreatment Evaluations, as applicable;
- Key updates on the member's permanency planning process;
- Identification of any restrictions to communicating with the biological/adoptive parents, including termination of parental rights or a court order restricting communication; and

- Other information necessary to inform the care management comprehensive assessment and care planning processes.

The care manager also establishes ongoing processes and timeframes for the county child welfare worker to share the DSS Child Health Summary Components, to the extent available, and establishes a schedule of regular check-ins between the care manager and the county child welfare worker, as required below. As necessary and appropriate, the care manager identifies health care services and health-related services, including State-funded behavioral health services, housing supports, and other supports necessary to support the member's biological/adoptive parents, promote reunification, and develop a plan for the county child welfare worker to make necessary referrals. Additionally, the care manager agrees on explicit next steps and roles and responsibilities to ensure the member's services are coordinated in a timely fashion. The care manager continues to schedule and attend meetings with the county child welfare worker at least quarterly, and more frequently as appropriate, throughout the member's involvement with the child welfare system.

During regular quarterly meetings, the care manager gathers the following updates:

- The member's foster care placement status;
- Key changes in the member's needs, including behavioral health and unmet health-related resource needs;
- Key updates on the member's permanency planning process;
- Any changes to restrictions to communicating with the biological/adoptive parents, including termination of parental rights or a court order restricting communication; and
- Other information necessary to inform the member's person-centered plan or care plan.

The care manager must contact the county child welfare worker within one business day when any of the following occur, to the extent information is available, and take necessary measures to ensure coordination of care:

- The member is admitted to an inpatient level of care or visits an emergency department (ED);
- The member is admitted to an institutional level of care or other congregate setting;
- The member experiences a behavioral health crisis;
- The member experiences a disruption in school enrollment (e.g., the member is expelled or required to change schools); or
- The member becomes involved with the justice system.

Care Management Comprehensive Assessment

Upon TCM provider assignment, the assigned care manager must initiate contact and make best efforts to begin the care management comprehensive assessment with the member within 30 calendar days of assignment. Members in foster care/the adoption assistance program and former foster youth are prioritized for outreach prior to beginning outreach to other members. The care manager must make "best efforts" to complete the assessment in person; however, based on the member's needs the assessment may be completed using audio and video conferencing tools. Vaya sends a monthly report listing all members who received the Standardized Unmet Health-Related Resource Needs screening as a required element of the assessment to NC Medicaid.

"Best efforts" are defined as at least three documented follow-up attempts to contact the member (such as going to the member's home or working with a known provider to meet the member at an appointment) if the first

attempt is unsuccessful, for a total of four attempts. These attempts must occur over a two-week period and include at least two of the following methods: telephonic, regular mail, email, or fax.

During Contract Year 1 of the Tailored Plan, the TCM provider is required to make its "best effort" to complete the care management comprehensive assessment within the following timeframes:

- Members identified as high acuity: best efforts to complete the assessment within 45 days and no longer than 60 days of plan enrollment
- Members identified as medium/low acuity: Within 90 days of plan enrollment
- Newly enrolled members following plan launch: Within 60 days of plan enrollment

The care management comprehensive assessment, at minimum, must address the following:

- Immediate care needs
- Current services and providers across all health needs
- Functional needs, accessibility needs, strengths, and goals
- Other state or local services currently used
- Physical health conditions, including:
    - Dental conditions
    - Chronic health conditions, including chronic pain (defined as pain that typically lasts greater than three months or past the time of normal tissue healing)
    - Acute health conditions
- Current and past mental health and substance use status and/or disorders, including tobacco use disorders
- Physical disabilities or I/DD
- Detailed medication history that includes a list of all medicines, including over-the-counter and prescribed drugs dispensed or administered, and known allergies
- Advance directives, including advance instructions for mental health treatment
- Available informal, caregiver, or social supports
- Standardized Unmet Health-Related Resource Needs questions provided by NCDHHS (i.e., the nine Care Needs Screening questions) covering the four identified priority domains:
    - Housing
    - Food
    - Transportation
    - Interpersonal violence/toxic stress
- Eligibility for Vaya's prevention and population health programs (for more information, visit our Provider Central website.
- Any other ongoing conditions that require a course of treatment or regular care monitoring
- (For adults only) exposure to adverse childhood experiences (ACEs) or other trauma
- Risks to the health, well-being, and safety of the member and others with whom they share a residence (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols)
- Cultural considerations (e.g., ethnicity, religion, language, reading level, health literacy)
- Employment/community involvement
- Education, including Individualized Education Programs (IEPs) and lifelong learning activities
- Justice system involvement (adults) or juvenile justice system involvement and/or expulsions or exclusions from school (children and adolescents)

- Risk factors that indicate an imminent need for LTSS
- Caregiver strengths and needs
- Upcoming life transitions (e.g., changing schools, employment, moving, change in caregiver/natural supports)
- Self-management and planning skills
- Receipt of and eligibility for entitlement benefits, such as Social Security benefits and Medicare

For members with an I/DD or TBI diagnosis, the care management comprehensive assessment must address the following additional elements:

- Financial resources and money management
- Alternative guardianship arrangements, as appropriate

For members ages 0 to 3, the care management comprehensive assessment also must incorporate questions related to early intervention (EI) services, including:

- Whether the member is receiving EI services
- Member's current EI services
- Frequency of EI services provided
- Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services
- Contact information for the CDSA service coordinator

For members ages 3 to 21 with a mental health and/or substance use disorder who are receiving behavioral health services, including members with a dual I/DD and mental health or substance use disorder diagnosis, the care management comprehensive assessment must incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family, and community.

For members participating in the Innovations or TBI waivers, the care management comprehensive assessment must include assessment requirements of the applicable waiver.

The care manager must incorporate the results of the Care Coordination Assessment into the care management comprehensive assessment, to the extent feasible. Vaya provides Care Coordination Assessment results to the TCM provider within seven calendar days of the screening or within seven calendar days of assignment to a new TCM provider, whichever is earlier. To prevent duplication of identification and assessment activities, Vaya also makes the Care Coordination Assessment results available to NCDHHS and any other designated care management entity (e.g., PCCM vendor, CAP/C or CAP/DA case management entity, CDSA, other LME/MCOs, PIHPs, and Prepaid Ambulatory Health Plan [PAHPs]) that may be serving the member within seven calendar days of the screening.

For members enrolled in the Innovations or TBI waivers prior to Tailored Plan launch and who engage in TCM:

- If the member's care plan annual update is in the first six months of Year 1 of Tailored Plan launch, Vaya's TCM Oversight Team ensures the assigned TCM provider completes the care management comprehensive assessment prior to completing the care plan.
- If the member's annual update is in the second half of Year 1 of Tailored Plan launch, Vaya ensures the assigned TCM provider completes the care management comprehensive assessment according to required

timeframes noted above for completion of the care management comprehensive assessment. Vaya ensures the TCM provider completes the assessment prior to the annual update, and, in subsequent years, aligns the timing of the reassessment with the care plan annual update.

- The care plan developed prior to Tailored Plan launch will continue to serve as the care plan under TCM in Year 1 of Tailored Plan operation, until updated.
- Vaya ensures the care plan is aligned with TCM requirements at the member's next annual update (during the month before the individual's birth month) after a triggering event or at the member's request. Prior to the annual update, the member's care management comprehensive assessment results may be used to amend the care plan if appropriate, but a full update is not required.
- When determining required care management contacts for Innovations or TBI waiver participants, the TCM provider must adhere to the following requirement that is higher in frequency and modality (e.g., number of in-person contacts):
    - The contact requirements found in the 1915(c) Innovations or TBI waiver; or
    - The contacts noted below in "Ongoing Care Management"
- For Innovations Waiver participants, Vaya ensures SIS results are shared with the care manager in an electronic format to aid completion of the care management comprehensive assessment.
- Assessment practices and requirements are informed by and coordinated with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.
- The care manager must share the results of the care management comprehensive assessment with the member's PCP and behavioral health, I/DD, TBI, and/or LTSS providers within 14 days of completion to inform care planning and treatment planning per member consent, if legally required.
- Reassessments for members engaged in TCM must be conducted according to the following requirements and within 30 days of the event or change:
    - On an annual basis (Vaya will also attempt to conduct a care management comprehensive assessment at least annually for members who have neither opted out of nor engaged in TCM and are not receiving services duplicative of TCM)
    - When the member's circumstances, needs, or health status changes significantly
    - After significant changes in scores on NCDHHS-approved level of care determination and screening tools (e.g., ASAM, Child and Adolescents Needs and Strengths [CANS], SIS, and Rancho Los Amigos Levels of Cognitive Functioning Scale)
    - At the member's request
    - After triggering events, including:
        - Inpatient hospitalization for any reason
        - Two ED visits since the last care management comprehensive assessment (including reassessment)
        - An involuntary treatment episode
        - Use of behavioral health crisis services
        - Arrest or other involvement with law enforcement/the criminal justice system, including DJJ
        - Becoming pregnant and/or giving birth
        - A change in member circumstances that results in an increased need for care, a decreased need for care, transition into or out of an institution, loss of a family/friend/caretaker, or any other event the plan deems to be a change in circumstance
        - Loss of housing
        - Foster care involvement

If a comprehensive assessment has been conducted withing the previous six months, reassessment consists of an addendum or update to a previous assessment.

Development of the Person-Centered Plan or Care Plan

The care manager uses the results of the care management comprehensive assessment to develop a person-centered plan or care plan that includes the following content and processes:

- Ensures meetings related to the member's person-centered plan or care plan are held at a location, date, and time convenient to the member and the member's chosen care team.
- Ensures each person-centered plan or care plan is individualized and developed using a collaborative approach that includes member and care team participation.
- Develops and presents the person-centered plan or care plan in an understandable manner, including consideration for reading level to support the member's understanding and ability to actively participate in the self-management aspects of their plan. The care manager explains and helps the member understand the plan. The care manager reviews the plan with the member to further refine it and prioritize goals; add additional concerns, goals, and/or interventions; and include the member's own language/words.
- Includes barriers to the accomplishment of each goal as needed and as identified by the care team.
- Ensures best efforts are made to complete an initial person-centered plan or care plan within 30 days of care management comprehensive assessment completion. The care manager ensures plan development does not delay the timely provision of needed services to a member, even if the member is waiting for a plan to be developed, except for services provided through the Innovations, TBI, or 1915(i) waivers, for which prior authorization must be documented in the person-centered plan or care plan. If a member needs a service offered though the Innovations or TBI waivers or the 1915(i) benefit before the plan is fully developed, the care manager completes the minimum elements for the SAR.
- Incorporates the results of the care management comprehensive assessment (including questions about unmet health-related resource needs), claims analysis and risk scoring, available medical records, and screening and/or level of care determination tools, including the following, as appropriate:
    - CANS
    - ASAM criteria
    - For Innovations Waiver participants: SIS
    - For TBI Waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale
- For interventions that include providing or discussing strategies with members to support management of their health conditions, contains, at a minimum:
    - Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery; and
    - Measurable member goals.
- Clinical needs, including any physical health, behavioral health, I/DD, TBI, or dental needs.
- Interventions, including medication management and adherence.
- Intended outcomes of interventions and goals.
- Social, educational, and other services needed by the member.
- Strategies to increase social interaction, employment, and community integration.
- Emergency/natural disaster/crisis plan.
- Strategies to mitigate risks to the health, well-being, and safety of the member and others.

- Information about advance directives, including advance instructions for mental health treatment, as appropriate.
- A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving, or entering another life transition.
- Strategies to improve self-management and planning skills.
- For members with serious emotional disturbance (SED), I/DD, or TBI, the person-centered plan or care plan should also include caregiver supports, including connection to Respite services, as necessary.

The care manager ensures the person-centered plan or care plan is regularly and comprehensively updated, incorporating input from the member and care team, at a minimum of every 12 months, when a member's circumstances or needs change significantly, at the member's request, and within 30 days of (re)assessment. The care manager also must routinely use member and care team input to establish a follow-up schedule to report progress toward goals and address barriers and any follow-up from counseling, referrals, member education, and self-management support.

For members ages 3 to 21 with a mental health and/or substance use disorder who are receiving behavioral health services, including members with a dual I/DD and behavioral health disorder diagnosis, the care manager ensures:

- A Child and Family Team (CFT) member is involved in developing the person-centered plan or care plan and facilitating the planning process.
- The strengths assessment is used to build strategies included in the plan that address the youth's and family's critical needs and unique strengths as identified by and in cooperation with the CFT. These strategies must be included in the person-centered plan or care plan.
- The plan is regularly updated to respond to changes with the youth/family and results of provided supports and services and to document the shift of activity from formal to informal supports for greater self-sufficiency.

Supervising care managers review all person-centered plans or care plans for completeness, quality, and coaching with care managers to ensure member needs are met. Vaya's TCM Oversight Team also conducts regular audits of comprehensive assessments, person-centered plans, and care plans developed by both plan- and provider-based care managers to ensure they meet quality expectations.

The care manager is required to ensure that each person-centered plan or care plan is documented and stored and made available to the member and the following representatives within 14 days of completion:

- Care team members, including the member's PCP and other physical health, behavioral health, I/DD, TBI, LTSS, and other providers delivering care to the member
- The member's legal representative (as appropriate)
- The member's caregiver (as appropriate, with consent)
- Social service providers (as appropriate, with consent)
- Other individuals identified and authorized by the member
- Care plans for Innovations Waiver participants must include all requirements within the TCM Provider Manual and any additional requirements outlined in the respective waivers.

Response Times for Inquiries from Key Partners

The care manager must have an expedited process to receive and respond to inquiries from medical providers, PCCM care managers, CAP/C and CAP/DA waiver case managers, state and local agencies (including DSS and DJJ), and any other care or case manager assigned to or responsible for a member. Callers must be able to reach specific, appropriate staff and receive help quickly and within the following timeframes:

- For urgent situations, the care manager must respond to inquiries within 24 hours of receiving them.
- For non-urgent situations, the care manager must respond to inquiries within three business days of receiving them.

The care manager participates in any member care team meetings to which they are invited by another care management, care coordination, or case management entity, including meetings convened by the PCCM vendor or CAP/C or CAP/DA case management entity.

Care Team Formation

The care manager is required to establish a multidisciplinary care team for each member that is based on the member's needs. The care manager ensures the team includes the following individuals (as applicable):

- The member (member participation is required)
- Caretaker(s)/legally responsible person (LRP). If the member has a LRP, care decisions are driven by what is best for the member based on ethical and best practices, not the convenience of the provider or caregiver/LRP.
- The member's care manager and the supervising care manager
- PCP
- I/DD and/or TBI providers
- Behavioral health providers
- Other specialists
- Nutritionists
- Pharmacists and pharmacy techs
- The member's obstetrician/gynecologist (for pregnant individuals)
- Peer support specialist
- In-reach and/or transition staff
- Other providers, as determined by the care manager and member

For members ages 3 to 21 with a mental health or substance use disorder who are receiving behavioral health services, the care manager ensures the care team incorporates the CFT. The CFT must be built around the youth and family to meet their unique needs and include relevant public and private providers, school representatives, and natural and community supports who actively participate in the implementation, monitoring, and evaluation of the person-centered plan or care plan. The CFT must be meet at least once every 30 days.

Finally, the care manager conducts and facilitates timely communication across the care team. Teams may meet electronically, telephonically, or in person and target the goals of the member's person-centered plan or care plan while meeting acuity-based contact requirements.

Ongoing Care Management

Ongoing care management includes tasks and interventions, referral, and linkage to treatment services and supports for unmet health-related resources needs, risk and disease management, and ongoing monitoring.

For children and youth receiving behavioral health services, ongoing care management also includes:

- Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports
- Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self-determination and enhance self-sufficiency
- Verifiable efforts for services and supports to be delivered in the community in which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs
- Use of family- and youth-friendly tools to document and demonstrate for the youth and family their progress over the course of treatment

Additionally, the TCM provider must:

- Provide or arrange for coverage for services, consultation or referral, and treatment for emergency medical conditions, including but not limited to behavioral health crises, 24 hours per day, seven days per week
- Have the ability 24 hours per day, seven days per week, to share information such as person-centered plans/care plans and advance directives and to coordinate care to place the member in the appropriate setting during urgent and emergent events

Care managers must make reasonable accommodations to meet at times and locations convenient to the member and their family for electronic, telephonic, and face-to-face meetings based on acuity and care needs. TCM incorporates individual and family supports, including:

- Training the member in self-management
- Providing education and guidance on self-advocacy to the member, family, and supports
- Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
- Providing information and connections to needed services and supports, including, but not limited to, self-help services, peer support services, and respite services
- Providing information to the member, family, and supports about the member's rights, protections, and responsibilities, including the right to change providers, the grievance resolution process, and fair hearing processes (this information is included in Vaya's Tailored Plan Member Handbook and NC Medicaid Direct Member Handbook, which are provided or made accessible to all members upon enrollment in a Vaya Medicaid health plan)
- Promoting health, including wellness and prevention programs
- Providing information about establishing advance directives, including advance instructions for mental health treatment and guardianship options/alternatives, as appropriate
- Connecting members and their family to resources that support maintaining employment, community integration, and success in school, as appropriate
- For high-risk pregnant individuals, inquiring about broader family needs, offering family planning guidance, and beginning discussions about a potential Infant Plan of Safe Care

- Coordinating with services provided by community and social support providers to address unmet health-related resource needs, including, at a minimum:
    - Provision of referral, information, and assistance and help obtaining and maintaining community-based resources and social support services, including:
        - Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery [SOAR])
        - Food and income supports
        - Housing
        - Transportation
        - Employment services
        - Education
        - Child welfare services
        - Domestic/interpersonal violence services
        - Legal services
        - Services for justice-involved populations
        - Other services that help individuals live their highest level of function and independence
- Using NCCARE360 to identify and connect the member to community-based resources by:
    - Using the community-based organization and social service agency resource repository to identify local, community-based resources
    - Referring the member to organizations and agencies available through NCCARE360
    - Tracking closed-loop referrals
- Providing comprehensive assistance securing key health-related services, including helping complete and submit initial applications and renewals and gathering and submitting required documentation. This assistance may be either in person or electronic, at the member's preference and depending on the most efficient, effective, and feasible approach. The care manager helps with support for the following programs, at a minimum:
    - Food and Nutrition Services (food stamps)
    - Temporary Assistance for Needy Families (Work First)
    - The Child Care Subsidy program
    - Low Income Energy Assistance Program (LIEAP)
    - ABLEnow Accounts (for individuals with disabilities)
    - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
    - Vaya Total Care programs that address unmet health-related resource needs
- Ensuring a member has a postpartum visit with a physician within 56 days of delivery to assess for signs of postpartum depression

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN PROGRAM (WIC)

TCM providers are required to identify members who may be eligible for WIC, make referrals, and provide comprehensive application assistance to help members access the WIC program as needed. Members who may be eligible for the WIC program include those who are pregnant, up to six months postpartum, breastfeeding up to one year postpartum, and under age 5.

CONTACT REQUIREMENTS

The care manager is required to meet the minimum contact requirements for members based on their acuity tier, as outlined below, unless the member expresses preference for fewer contacts and this preference is documented in the person-centered plan/care plan and reviewed with the care manager's supervisor. Innovations Waiver participants may have different contact requirements as referenced below. Contacts that are not required to be in person may be telephonic or through two-way, real-time video and audio conferencing. If the care manager uses two-way, real-time video and audio conferencing, they must enable applicable encryption and privacy modes and provide notice to the member that the third-party application potentially introduces privacy risks. Public-facing video communication applications, such as Facebook Live, Twitch, or TikTok, may not be used. The administration of the care management comprehensive assessment may count as one of the contacts. The care manager ensures in-person contacts occur at a location, date, and time convenient to the member and their chosen participants.

Required contacts for members with behavioral health needs are:

- **High acuity:** At least four care manager-to-member contacts per month, including at least one in-person contact
- **Moderate acuity:** At least three care manager-to-member contacts per month and at least one in-person contact quarterly (includes the care management comprehensive assessment, if conducted in person)
- **Low acuity:** At least two care manager-to-member contacts per month and at least two in-person contacts member contacts per year, approximately six months apart (includes the care management comprehensive assessment, if conducted in person)

Required contacts for members with I/DD or TBI are:

- **High acuity:** At least three care manager-to-member contacts per month, including at least two in-person contacts
- **Moderate acuity:** At least three care manager-to-member contacts per month and at least one in-person contact quarterly (includes the care management comprehensive assessment, if conducted in person)
- **Low acuity:** At least one telephonic or two-way, real-time video and audio conferencing contact per month and at least two in-person care manager-to-member contacts per year, approximately six months apart (includes the care management comprehensive assessment, if conducted in-person). If the member is dually diagnosed with a behavioral health condition and I/DD or TBI, the TCM provider determines which contact requirements apply based on what is clinically appropriate. For members with I/DD or TBI who have a guardian, telephonic or two-way, real-time video and audio conferencing contact may be with a guardian in lieu of the member when appropriate or necessary. In-person contacts must involve the member.

For members who request accommodations due to relevant health conditions, contacts can be delivered, at the discretion of Vaya, the AMH+, or the CMA, using clinically-appropriate assistive technologies (e.g., speech-to-text application, secure platforms for two-way instant messaging/texting). If the care manager/extender/supervising care manager uses two-way instant messaging/texting with a member who requests accommodations due to relevant, specific health conditions, the instant messaging/texting must be via a secure portal that has met all NCDHHS-required security and privacy requirements. Member preferences for contact frequency and accommodations requests should be documented in the person-centered plan/care plan and reviewed with the supervising care manager. The updated person-centered plan/care plan should be signed by the member or their legally responsible person/guardian.

COORDINATION WITH COUNTY CHILD WELFARE WORKERS FOR MEMBERS INVOLVED IN THE CHILD WELFARE SYSTEM ENGAGED IN TCM

- For members in foster care/the adoption assistance program and former foster youth, the TCM provider ensures close coordination, as appropriate, with the assigned DSS county child welfare worker to identify and manage emerging member needs.
- At the request of the county child welfare worker and at the member's discretion, the TCM provider participates in the initial development of and periodic updates to the member's Transitional Living Plan. The TCM provider works in partnership with the member's other providers to help the member and county child welfare worker identify key health care-related goals, as well as resources and supports needed to meet those goals, to include in the member's Transitional Living Plan.
- The care manager participates in the development of the member's DSS 90-Day Transition Plan with the assigned county child welfare worker, family, providers, and other support individuals at the discretion of the member and county child welfare worker. The DSS 90-Day Transition Plan includes accurate, up-to-date contact information for the member's care manager, PCP, dental home, behavioral health and/or I/DD providers, and current medications, as applicable.
- For members who remain enrolled, the care manager makes best efforts to conduct the comprehensive assessment /reassessment within 90 calendar days of the member leaving the child welfare system.

Vaya's TCM Oversight Team ensures both provider- and plan-based TCM providers meet program requirements. In addition, AMH+s and CMAs may work with CINs or other partners to meet TCM requirements. AMH+s and CMAs may decide to enter into arrangements with Tailored Plans for use of their information technology (IT) products or care management data systems. In this case, the Tailored Plan is considered an "other partner" (not a CIN) for health IT (HIT) support only. To the extent that a CIN or other partner contracts with a Tailored Plan on behalf of an AMH+ or CMA, the Tailored Plan must conduct oversight of the CIN or other partner. To the extent an AMH+ or CMA contracts with a CIN or other partner, the requirements and capabilities applicable to the AMH+ or CMA apply to the CIN or other partner.

Other Care Management Programs

Although TCM serves as the predominant care management model for members, Vaya recognizes additional care management options for specific populations. These include LHDs; pregnancy management programs; HIV case management providers; High-Fidelity Wraparound, ACT, ICF/IID, and Children's Developmental Services; and care management through the Indian Health Service (IHS). Vaya coordinates with other care management programs to avoid duplication and promote smooth transitions between services.

CARE MANAGEMENT FOR AT-RISK CHILDREN (CMARC)

Vaya ensures LHDs have the information they need to refer members transitioning from CMARC to TCM by notifying Vaya's Member and Recipient Services Department. Vaya updates the member's status in the Eligibility and Assignment Database, and the member is assigned to a TCM provider. Vaya-based care managers support smooth transitions and warm handoffs with the LHD. When a member is receiving CMARC, the care manager and the CMARC provider must explicitly delineate responsibilities and document this agreement in the person-centered plan or care plan to avoid service duplication.

CARE MANAGEMENT FOR HIGH-RISK PREGNANT WOMEN (CMHRP)

Vaya supports members with high-risk pregnancies to promote healthy outcomes for both baby and parent by coordinating with Care Management for High-Risk Pregnant Women (CMHRP) delivered through systemic and individual interventions. When a pregnant member is identified, Vaya uses a variety of methods to determine risk status, including standardized risk screening tools to identify high-risk issues, risk stratification, and direct referral by providers, members, and families. Vaya assesses the level of TCM interventions and support the member may need and sends all screening information to the applicable LHD to begin providing CMHRP within one business day of the referral.

During Contract Year 1, when Vaya receives a high-risk pregnancy referral from a provider, member, family, or another entity, the member is enrolled in CMHRP, and Vaya notifies the member's Pregnancy Management Program (PMP) provider. When referring to CMHRP, Vaya offers the right of first refusal to the applicable LHD. After Contract Year 1, Vaya may continue to contract with LHDs for CMHRP or opt to integrate CMHRP services into TCM for members with high-risk pregnancies (whether provided by TCM provider or by another organization under contract with Vaya). If an LHD declines to serve the member, Vaya assigns the member to a TCM approach following standard PCP and TCM assignment processes.

A member can receive CMHRP and TCM simultaneously. In this case, the TCM provider works closely and collaboratively with the LHD care manager to deliver parallel but unduplicated service components to meet all the member's needs and share pertinent information. In addition, the care manager inquires about broader family needs, offers guidance on family planning, and begins discussions about a potential Infant Plan of Safe Care. In all cases, the TCM provider coordinates and collaborates with the member's PMP provider, PCP, and/or OB-GYN to ensure interventions are complementary and that the member experiences these services in the context of a multidisciplinary care experience.

CMHRP interventions must include, but are not limited to:

- Engagement/outreach
- Motivational interviewing
- Assessment of health needs and barriers to care in the development of the person-centered plan
- Help arranging transportation for health care appointments
- Identification of community resources available to meet specific member needs
- NCCARE360 referrals to resources that address unmet health-related resource needs
- Linkage to educational supports, such as family planning, breastfeeding classes, childbirth classes, oral health care, and other needed Medicaid-covered services
- Education about and access to Vaya's value-added services that support pregnant and postpartum members
- Medication reconciliation
- Transitional housing services, including housing, unmet health-related resource needs support, and treatment services
- Comprehensive integrated perinatal and substance use disorder treatment support
- Behavioral health treatment
- Medication-assisted treatment (MAT)
- Substance use disorder detoxification
- Inpatient substance use disorder treatment
- Education to decrease stigma about and barriers to substance use disorder treatment and OB-GYN care

In addition to standard contract terms and any additional terms mutually agreed upon between Vaya and the LHD, all NCDHHS-defined care management practice standards for CMHRP are included in contracts with LHDs. In the event of underperformance by an LHD, Vaya must follow procedures specified by NCDHHS. In the event of continued underperformance by an LHD, Vaya is permitted to terminate the contract with that LHD, and the LHD has the right to appeal the termination. Vaya must notify NCDHHS of underperformance by or contract termination of an LHD.

Care managers serving CMHRP participants receive training on the referral process and strategies for serving pregnant and postpartum members. Training includes best practices to address the needs of pregnant and postpartum members with a substance use disorder or a history of a substance use disorder, general pregnancy knowledge, strategies, and infant opioid withdrawal. Vaya provides training about the Infant Plan of Safe Care and the population of infants and families whom North Carolina identifies as "substance affected" per the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act of 2016 (CARA). Vaya works with LHDs on community initiatives, referrals, interventions, and customized training to maximize resources and supports available to members with high-risk pregnancies.

PREGNANCY MANAGEMENT PROGRAM (PMP) IN COORDINATION WITH CMHRP

1. Vaya is required to participate in NCDHHS-led meetings involving the PMP program, including requiring attendance by appropriate clinical and operational leadership.
2. Vaya is required to incorporate new guidance, policy, operational manuals, and other program-specific requirements into Tailored Plan operations and PMP contracts, as applicable, and within NCDHHS-specified timelines.
3. Vaya is required to adopt the PMP standardized screening tool currently used in practices, with modifications, as determined by NCDHHS.
4. Vaya is responsible for receiving standardized screening tool results from PMP providers and arranging enrollment into CMHRP based on referrals by PMP providers.
5. During Contract Year 1, when a member with a high-risk pregnancy is referred to Vaya by a PMP provider, the member, family, or another entity, Vaya is responsible for arranging the member's enrollment into CMHRP and informing the member's PMP provider of the enrollment.

HIV CASE MANAGEMENT

Vaya contracts with local infectious disease providers to deliver short-term, goal-oriented HIV case management to meet the specific, immediate member needs. HIV case management includes assessment, care planning, resource development, services coordination, monitoring, reassessment, and discharge.

COORDINATION WITH CHILDREN'S DEVELOPMENTAL SERVICE AGENCIES (CDSAs)

Vaya coordinates with every Early Intervention (EI) Program Children's Developmental Service Agency (CDSA) in our region. For children actively engaged in TCM, the care manager coordinates and facilitates information-sharing with the CDSA service coordinator to the maximum extent possible. When the needs assessment identifies any child ages 0 to 3 who is receiving EI services, the care manager must:

1. Incorporate the child's Individualized Family Service Plan (IFSP) into the person-centered plan or care plan;
2. Update the plan on an ongoing basis to reflect any changes to the IFSP;

3. Request that the CDSA service coordinator participate in the child's care team meetings, upon consent of the parent/LRP; and
4. Partner with the CDSA service coordinator to identify any unmet health-related resource needs and connect the family to appropriate social and community-based services.

For any child ages 0 to 3 who is not receiving EI services, but whose assessment shows evidence of developmental delay, the care manager must provide referral information to the parents/guardian for an EI evaluation, facilitate a warm handoff to the appropriate CDSA, and follow up on the referral results and whether an EI evaluation was conducted. Vaya ensures appropriate staff are knowledgeable about EI services and provide referrals to the appropriate CDSA.

TRIBAL OPTION

Vaya works closely with the IHS and the EBCI through our Tribal Engagement Strategy, which includes culturally sensitive care management and coordination for Tribal members and IHS-eligible individuals. At the request of NCDHHS, Vaya will perform care management or other functions for EBCI Tribal members and IHS-eligible individuals as prescribed by NCDHHS and in consultation with the EBCI. If a TCM participant is enrolled in the Tribal Option for primary care case management, the care manager collaborates with the Tribal Option to ensure coordination of care and avoid duplication of care management services.

PRIMARY CARE CASE MANAGEMENT (PCCM)

Members may receive PCCM services from Community Care of North Carolina (CCNC) based on their Medicaid category of aid. In some instances, CCNC and Vaya may provide different elements of care management/ coordination of care. Vaya collaborates with CCNC as follows:

- Vaya checks the PCCM Care Management Information System to determine whether a member receiving care coordination has a PCCM care manager and, if so, coordinates with the PCCM care manager.
- Vaya shares the results of any assessments and the member's person-centered plan or care plan (to the extent one exists) with the PCCM care manager.
- Vaya, with the assistance of the PCCM care manager, encourages, supports, and facilitates communication among PCPs and other network providers regarding medication management, shared roles in care transitions and ongoing care, the exchange of clinically relevant information, annual exams, coordination of services, case consultation, and problem-solving, as well as identifying a medical home for members, if needed.
- Vaya accepts care coordination referrals from PCPs and PCCM care managers, determines the level of care coordination services needed, and provides referral status feedback to the referring provider or PCCM care manager within five business days. If care coordination is not warranted, Vaya notifies the referral source and offers other ways Vaya can help connect the member to treatment.

Members who are not receiving TCM may obtain both care management through the PCCM vendor and care coordination through Vaya under the following arrangements:

- Vaya is the lead care coordination entity for members with a behavioral health transitional care need.
- For all other members receiving both care management through the PCCM vendor and care coordination through Vaya, the PCCM vendor takes the lead in coordinating the member's care.

For members with a behavioral health transitional care need who have a PCCM care manager, Vaya performs the following additional responsibilities:

- Notifies the PCCM care manager the member is undergoing a transition and engages the PCCM care manager in helping the member transition into the community, including in developing the 90-day post-discharge transition plan
- Shares the transitional care assessment and 90-day post-discharge transition plan with the PCCM care manager
- Identifies in the 90-day post-discharge transition plan the role the PCCM care manager plays in ensuring a successful transition
- During the week of the transition, ensures the member is discussed in the weekly conference between Vaya and the PCCM vendor

Vaya defers to the PCCM care manager as the lead care manager for members in foster care/the adoption assistance program and former foster youth who do not otherwise meet Tailored Plan eligibility criteria. However, Vaya honors any county DSS/child welfare worker request to assign an ongoing care manager (e.g., if the county child welfare worker needs additional support to connect the member to behavioral health services). Vaya ensures care managers and supervising care managers receive training on coordinating care with the PCCM vendor and CAP/C and CAP/DA waiver case management entities.

Healthy Opportunities Pilot (HOP)

In partnership with network lead Impact Health, Vaya will administer the State's Healthy Opportunities Pilot program for eligible Tailored Plan and NC Medicaid Direct members in 16 counties: Avery, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, and Yancey. The pilot program covers a select set of non-medical, evidence-based services for high-risk health plan members. Services address housing, interpersonal safety/toxic stress, food, and transportation to improve member health and well-being. To qualify, individuals must:

- Be enrolled in an NC Medicaid Managed Care plan or eligible for TCM;
- Live in a pilot region;
- Have at least one qualifying physical or behavioral health condition; and
- Have at least one qualifying social risk factor.

TCM providers have the following responsibilities for participating members:

1. Evaluating members using an NCDHHS-developed Pilot Program Eligibility and Service Assessment (PESA) form in NCCARE360 to assess whether they meet baseline eligibility criteria
2. Integrating a member's need for, authorization of, referral to, and status of HOP
3. services into the member's person-centered plan or care plan
4. Securing HOP program enrollment and authorization of HOP services
5. Obtaining authorized members' HOP program participation consent, including for enrollment, services, and information-sharing, based on NCDHHS guidance
6. Communicating approved HOP enrollment determination and service authorization to members
7. Referring members approved for HOP program enrollment and specific HOP services to human service organizations in the Impact Health network for approved services and tracking HOP services delivered to participants by conducting "closed-loop referrals" using the NCCARE360 platform.
8. Conducting a reassessment of:

   a. Eligibility for specific HOP services no less frequently than every three months, or earlier if a member experiences a change in eligibility for an identified service, resource, or program that can meet the member's HOP service need, including those managed directly by Vaya; and,
   b. Eligibility for the HOP program and services no less frequently than every six months.
9. Supporting NCDHHS' HOP program oversight and evaluation efforts by providing information and data on participants and program operations in accordance with NCDHHS guidance
10. Meeting any other HOP-related requirements outlined by NCDHHS.

For additional information about the Healthy Opportunities Pilots, including specific services available, visit the NCDHHS HOP webpage.

Network Provider Coordination Responsibilities

Network providers must fully cooperate with organizations providing TCM and integrated care activities, including, but not limited to, the following:

- Actively participate in interdisciplinary team meetings convened or arranged by the care manager and/or include the care manager in team meetings convened or arranged by you
- Provide at least 24 hours prior notice to the care manager of the date, time, and place of any treatment team or discharge planning meeting involving a member with an assigned care manager
- Provide accurate and timely information to the care manager regarding the member's participation in treatment and clinical progress
- Work with the care manager and child and family or adult planning team in developing an appropriate, whole-person plan of care (person-centered plan or care plan), including crisis planning for individuals regardless of disability type (treatment plans must address mental health, substance use disorder, I/DD, medical, dental, and specialty needs, as well as evidence of medication reconciliation across all care providers and a detailed, cross-system Comprehensive Crisis Plan (CCP) using evaluations, assessments, and collateral information)
- Develop and implement treatment and/or supports strategies to address assigned areas of responsibility from the person-centered plan or care plan
- Develop step-down and discharge plans within the first month of admission
- Actively engage in planning with the care manager for transitions to other levels of care
- Permit transition staff, including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator to engage in and help coordinate the discharge planning process
- Notify Vaya of member admissions/pending discharges and contact the assigned organization providing TCM (if applicable) to integrate the organization into the discharge/transition planning process
- Share relevant information (including the member's current person-centered plan or care plan, initial and final discharge plans, and medical information, when applicable) among transition/discharge planning team members and the member's care team, if applicable
- Notify the assigned care manager whenever a member receiving TCM is admitted to an ED, FBC facility, or inpatient unit
- Provide accurate information to members and their families regarding clinical coverage policies and levels of care that are typically most effective at treating or supporting a member's treatment or habilitative needs and helping a member and their family plan for multiple treatment options

- Complete, timely and accurately, all appropriate or required level of care/clinical decision support tools identified in Section 3 of this manual, including, but not limited to, ESCII, CANS-Mental Health, NC-SNAP, SIS® and ASAM placement criteria
- Work with Vaya's transition team, TCM provider, primary care providers, and other Vaya-contracted providers regarding a member's medical management, shared roles in the care and crisis plans, 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 Centers. Any application for a State Developmental Center must be coordinated with Vaya, as we are responsible for ensuring all NC Division of State-Operated Healthcare Facilities (DSOHF) admission criteria and protocols are met. The member/ LRP or network provider must provide Vaya with all information necessary to determine if an application to a State Developmental Center should be made and for submission of a complete admission packet. Assigned I/DD Care Managers and Vaya's I/DD Transition Coordinator will review the application to ensure all other reasonable, lower levels of care were exhausted first. Vaya must provide a letter of support to the DSOHF for an application to be accepted. Individuals accepted into a State Developmental Center will be followed by the I/DD Transition Coordinator 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 (MOA) for one year. All individuals will be discharged the date stated on the MOA. Vaya will ensure timely execution of the MOA with the member's guardian regarding the member's discharge plan.
- If the member has a behavioral health home and receives services that include certain care coordination, care management, or case management activities per the applicable NC Medicaid CCP, the Division of MHDDSUS State-funded services definition or the network provider's contract with Vaya, the behavioral health home will ensure the member's care coordination/ management needs are met via the network provider and that activities are not duplicative. A failure to provide required care coordination services or cooperate with the assigned care manager may result in a referral for investigation and may lead to administrative action or sanction, up to and including termination of contract. In cases in which there is not an identified behavioral health home, the assigned care manager will provide certain TCM activities and functions outlined in Vaya's contracts with NC Medicaid and the Division of MHDDSUS based on the population served.

In-reach: Transitions to Community Living (TCL)

Vaya administers the Department's Transitions to Community Living (TCL) program in our region. TCL gives eligible adults (ages 18 or older) with serious mental illness (SMI) or severe and persistent mental illness (SPMI) who are living in an institution or at risk of institutional placement (i.e., homeless or living in unstable housing) the opportunity to live in the community of their choice. TCL stems from a 2012 settlement agreement between the state of North Carolina and the U.S. Department of Justice. Vaya's TCL Team is a specialty care management team that serves eligible TCL participants and links them to wraparound mental health and other support services that help them live in a home, rather than a facility.

TCL allows eligible individuals to engage in leased housing, learn everyday skills, take part in community activities, and develop lasting relationships. Participants receive behavioral health services, employment assistance, and help becoming part of the community. Vaya's TCL program focuses on six areas:

- **In-reach and Transition:** Education and discharge planning for people living in ACHs and state psychiatric hospitals (providers who are contracted to deliver ACT, Tenancy Supports, SE, or other services associated with TCL must actively participate with Vaya's in-reach and transition activities)
- **Diversion:** Information on housing options for people with SMI/SPMI at risk of admission to an ACH
- **Housing:** Community-based, supportive housing with assistance for tenants
- **Supported Employment:** Help preparing for, identifying, and maintaining paid, competitive employment alongside people without disabilities
- **Quality Management:** Use of data to measure progress and results
- **ACT/Tenancy Support:** Intensive, community-based, person-centered behavioral health treatment that includes a variety of services, at least one of which must be considered as Tenancy Support. Tenancy Support services include Transition Management Services (TMS), Critical Time Intervention (CTI), Community Support Team (CST), and ACT. Tenancy Support services should focus on rehabilitation skills intended to increase and restore an individual's ability to live successfully in the community and maintain tenancy. They should focus on increasing the individual's ability to live as independently as possible, managing the illness, and reestablishing their community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal.

HOW CAN A NETWORK PROVIDER REFER AN INDIVIDUAL TO TCL?

Individuals who are eligible for TCL consideration must meet specific criteria for referral (formerly PASRR; currently the Referral Screening Verification Process, or RSVP). Referrals are made online at MyHousingSearch.com – RSVP. If the individual has a guardian who is considered a "guardian of the person or general guardian," but NOT the "guardian of the estate," the guardian of the person/general guardian MUST be notified BEFORE making the referral.

To be considered for TCL, the individual must meet the following criteria:

- Be at risk for admission into an ACH or other adult living facility
- Have a SPMI/SMI diagnosis; may have other co-occurring behavioral health needs
- Be eligible for Medicaid in North Carolina
- Have a monthly income of $2,000 or below
- Be age 18 or older and willing to accept a minimum of one tenancy support per month

If you are working with an individual you would like to refer for TCL consideration, complete an RSVP. Vaya's Member and Recipient Services Department screens referrals within 30-45 days.

WHAT ARE THE NETWORK PROVIDER'S RESPONSIBILITIES IF THE INDIVIDUAL IS INVOLVED WITH TCL BUT NOT YET HOUSED?

The preliminary visits for TCL begin with in-reach staff and ongoing assessment of housing needs, mental health supports, and Supported Employment options. During this time, it is important providers support the individual and the in-reach staff by providing information about the person's needs, historical obstacles, and future goals and strengths. The provider should begin collaborating with TCL staff to continue options counseling to help the individual identify and move to supportive, independent living. Providers should attend meetings (as needed), complete and produce all supporting verification documentation, help identify housing, and assist with the move.

WHAT ARE THE NETWORK PROVIDER'S RESPONSIBILITIES IF AN INDIVIDUAL IS ALREADY HOUSED THROUGH TCL?

The provider's primary role is to help the individual maintain housing by providing tenancy supports and ensuring the member integrates into their community, creating a meaningful day. Members should practice and enact appropriate cleanliness standards, safety and security, visitor management, medication routines, and lease obligations. Tenancy supports providers must provide a monthly update to Vaya's transition coordinator about the member and alert them to all significant housing or health-related events, including, but not limited to, the member being hospitalized, experiencing a serious illness or receiving a new diagnosis, losing housing, becoming homeless, incurring one or more lease violations, having unpaid bills that could result in loss of lease, having law enforcement or other legal interactions, or having eloped or been unaccounted for more than 72 hours.

WHAT IF THE MEMBER IS LOSING HOUSING OR AT RISK OF LOSING HOUSING?

If the member is at risk of losing housing, the provider should convene a team meeting and include the transition coordinator in eviction avoidance planning. Network providers are responsible for partnering with TCL staff to help resolve and prevent disputes between landlords and TCL participants that could lead to eviction.

ARE THERE ANY SUPPORTED EMPLOYMENT REQUIREMENTS FOR NETWORK PROVIDERS?

Yes. The primary outcome of Individual Placement Support – Supported Employment (IPS-SE) is competitive employment in an integrated setting (50 percent or more non-disabled staff) consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, and interests and involving informed choice. To establish a valued sense of integrity and purpose within IPS-SE/Long-Term Vocational Support (LTVS), providers must participate in trainings to implement evidence-based IPS-SE within your organization as applicable and help gather/collect and report requested data to Vaya for use in determining needs and barriers to employment within our region.

Providers contracted to provide IPS-SE or ACT must provide IPS-SE program data that includes member development/phase of service (i.e., job development, creation of small business/micro-enterprise, placement, or LTVS) and outcomes, including the number of individuals who obtained jobs, their start date, hours worked, wages, benefits, and pertinent employer information. Providers must submit quarterly reporting electronically to Vaya at SupportedEmployment@vayahealth.com.

HOUSING SUPPORTS

Having a safe and stable place to live is an integral part of well-being and recovery. Vaya follows the "Housing First" approach, which prioritizes providing permanent housing to people experiencing homelessness, thus creating a platform from which they can pursue personal goals and improve their quality of life. One of the primary barriers to stability and avoiding a crisis is lack of housing. **Unfortunately, housing supports are not an entitlement, and funds are limited.**

Network providers are required to collaborate with Vaya's housing efforts and participate in or refer landlords and other stakeholders to Vaya's housing initiatives. As needed, providers must help members remain stably housed.

Providers who are contracted to provide State-funded Residential Services (SFRS) must:

- Maintain a current list of members for whom the organization receives SFRS funding
- Submit Unused Bed Day Census reports monthly
- Notify Vaya of vacancies within one day
- Follow SFRS referral process guidelines.

Providers who signed a memorandum of agreement (MOA) with Vaya to make Permanent Supportive Housing (PSH) program referrals must:

- Render ongoing services to PSH-referred participants, as needed, and provide monthly reports of those services
- Communicate regularly with the Vaya Housing Team when changes occur, such as the participant's stability, income, household composition, etc.

Provider Collaboration Related to TCL

Vaya strives to remove barriers to care and ensure individuals can access services as quickly as possible. As part of this approach, Vaya educates network providers on needed support and documentation for TCL participants. See the list below of required documents and applicable timelines to help TCL participants transition to their new home in an efficient, timely manner.

Ensuring individuals are living in safe, decent, and affordable housing is essential to treatment retention and success. When a person is facing eviction or living in homelessness or substandard housing, it is imperative that every effort be made to avoid eviction or to rapidly re-house a person. Active housing intervention can require daily efforts to find suitable housing and help the person with applications and leasing requirements.

Searching for stable housing can include:

- Looking for apartments online through nchousingsearch.org, Apartment Finder, etc.
- Having knowledge of local affordable housing properties and reaching out to property managers for vacancies, including searching for targeted/key units
- Accessing funding to aid with move-in costs or eviction prevention
- Preparing for mitigation of housing barriers through reasonable accommodation requests
- Asking for technical help from Vaya's Housing Team and following up on leads
- Maintaining a list of potential property owners in private rental markets
- Accessing boarding houses as temporary living options to avoid or exit homelessness
- Enforcement of fair housing laws that require property owners to make necessary repairs to avoid tenant displacement due to substandard conditions
- Placing individuals on local housing authority waitlists for Housing Choice vouchers/public housing

Providers are required to:

- Include any supporting documentation with referrals made through RSVP or upon request from the assigned Vaya diversion specialist once contact is made (decisions are rendered within five to seven business days of the referral date)
- Help obtain vital documents for program applications
- Within 10 business days of the initial request from TCL staff, develop a person-centered plan with the participant that integrates the TCL Transition Tool and adhere to the following timeframes:

  - Within a week of the first transition meeting, the transition coordinator sends the tool to the provider to integrate into the participant's person-centered plan
  - The provider returns the plan within two weeks
  - Once the updated plan is received, the transition coordinator has 72 hours to return it to the provider with any corrections or feedback
  - Providers may reach out to the transition coordinator for support, as members cannot move in without a complete, approved plan that includes all required signatures
  - Providers have one week to return the person-centered plan and signature page to Vaya with any corrections and all RN/occupation therapy recommendations
- Attend initial, final, and post-transition meetings throughout the in-reach and transition phases
- Communicate with TCL in-reach staff and transition coordinators
- Complete the provider portion of the TCL Transition Tool within 14 days of request from TCL staff
- Assist with discharges from hospitals and other crisis centers (e. g., moving, transportation, etc.)
- Complete and submit the TCL Community Inclusion Monthly Update for all housed TCL members by the first business day of the new month
- Communicate as needed to inform the transition coordinator of any health or safety issues, housing concerns, tenant-landlord issues, any issues that jeopardize housing stability, etc.
- Provide time-sensitive information on the Community Inclusion Monthly Monitoring form
- Help complete and obtain signatures on TCL Voucher Forms
- Help the member complete the ACH FL2 form and apply for Special Assistance/In-home (SA-IH)
- Once a member is approved for SA-IH, keep track of annual renewal dates to prepare and help complete yearly recertification documentation for rental assistance (e.g., SA-IH), including an FL2
- Monitor SA-IH and Community Living Assistance (CLA) funding utilization
- Help the participant prepare for and schedule their annual unit inspection
- Attend and provide supports during lease-signing and move-in
- Ensure the member can live in the unit upon move-in
- Help the member shop for items needed to maintain community living
- Check in with the member daily (seven days/week) during the first week after they move into housing
- Participate in separation conversations/meetings
- Help get documents signed
- Help members separate from housing (e.g., move furniture, find secure storage, work with natural supports)
- Actively explore and pursue community inclusion opportunities, with an emphasis on IPS-SE
- For Tenancy Support Services (TSS) providers, fully implemented TSS by supporting members in the home, including side-by-side support as needed, ensuring tenancy stability
- Help the member apply for/obtain recertification for Social Security Disability Insurance (SSDI) and Medicaid
- Notify Vaya TCL and Provider Network Operations Department staff when referring members to additional services or discharging them from services
- Complete a new Comprehensive Clinical Assessment (CCA) every two years (if a CCA is one year old, the provider may complete an addendum in lieu of a new CCA)
- Help the member apply for mainstream vouchers
- For tenancy supports providers, ensure an average of no less than three face-to-face contacts with housed TCL participants per week, until barriers are eliminated
- Notification Vaya TCL staff of any application denials, lease violations, rehouses, notice to vacates, or unexpected member absences from the unit

Transitional Care Management

TCM comprises transitional care management, which includes managing transitions when members move into and out of the Tailored Plan and between Tailored Plans, as well as clinical transitions to and from different levels of care. Regardless of the organization providing TCM, Vaya oversees care transitions for all members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i).

Transitional care management includes a systematic, clinically appropriate process with designated staffing for care managers responding to situations such as high-risk admission, discharge, and transfer (ADT) alerts (e.g., related to a visit to the ED or hospital). Vaya supports TCM providers to receive ADT notifications within a clinically appropriate time period.

Transitional care management must include the following functions:

- Real-time (within minutes/hours) response to notifications of ED visits (e.g., by contacting the ED to arrange rapid follow-up)
- Same-day or next-day outreach for designated high-risk subsets of the population
- Additional outreach within several days after the alert to address outpatient needs or prevent future problems for individuals discharged from an ED or hospital (e.g., helping schedule appropriate follow-up visits or medication reconciliations)

Diversion from Institutional Settings

TCM providers also offer diversion interventions for members who are identified as at risk of requiring care in an institutional setting or ACH.

ELIGIBILITY FOR DIVERSION

Members eligible for diversion activities include those meeting the following criteria:

1. Have transitioned from an institutional or correctional setting, or an ACH for adult members, within the previous six months; or
2. Are seeking entry into an institutional setting or ACH; or
3. Meet one of the following additional criteria for members with I/DD or TBI:
    a. The member has an aging caregiver who may be unable to provide required interventions; or
    b. The member's caregiver is in fragile health, which may include, but is not limited to, caregivers who have been hospitalized in the previous 12-18 months, have been diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition); or
    c. A member who has two parents or guardians, and one of those parents/guardians dies; or
    d. Any other indications that a member's caregiver may be unable to provide required interventions; or
    e. The member is a child or youth with complex behavioral health needs.

DIVERSION ACTIVITIES

The TCM provider performs the following diversion activities in a timely manner:

- Screens and assesses the member for eligibility for community-based services

- Educates the member about the choice to remain in the community and services available to support that decision
- Facilitates referral and linkages to community-based and other support services
- Determines if the member is eligible for Supportive Housing, if needed
- For members who choose to remain in the community:
    - Develops a Community Integration Plan (CIP) that clearly documents that the member's decision to remain in the community was based on informed choice and the degree to which the member's decision has been implemented
    - Integrates the member's CIP as an addendum in their person-centered plan or care plan (ISP).
    - For members with a CIP, refers and provides linkages to services and supports for which they are eligible, including Supportive Housing

The TCM provider must ensure all diversion activities are documented, stored, and made available to Vaya for review upon request.

DATA SYSTEMS AND DATA SHARING IN SUPPORT OF TCM

Vaya ensures TCM providers have access to an ADT data source to identify when a member is admitted, discharged, or transferred to/from an ED or hospital in real or near-real time. Following TCM assignment, Vaya shares the following data with AMH+ practices, CMAs, CINs, or other partners:

- Clinically relevant and available enrollment/eligibility data
- Point-in-time assignment information, at least monthly
- Projected assignment information for the following month (to the extent information is available)
- Information about members newly assigned to the Tailored Plan (within seven business days of enrollment)
- Notifications of any ad hoc changes in assignment as they occur (within seven business days of each change)
- Acuity tiering results for every assigned member and any changes to a member's acuity tier assignment (shared within seven business days of each update)
- If/when risk stratification is employed by Vaya, additional risk scoring results for every assigned member, including (where possible and relevant) member-level information about cost and utilization outliers
- If/when risk stratification is employed by Vaya and when feasible, types or categories of risk stratification model inputs (e.g., frequency of hospital utilization) and clinically relevant information identified through the risk score development process that can inform specific actions by the AMH+ or CMA

Duplication of Care Management

TCM providers must coordinate with other care management programs to ensure care management is not duplicated and to promote a smooth transition when members transition to or from TCM. Other care management programs duplicative of TCM include Care Management for At Risk Children (CMARC) and Care Management for High-Risk Pregnancy (CMHRP) provided by LHDs, Pregnancy Management Programs, case management provided through ACT and ICF/IIDs, and care management provided as part of High-Fidelity Wraparound (HFW). When a member is receiving a service other than those listed above that has potential for duplication with TCM, the care manager and the provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the person-centered plan or care plan (ISP). Providers delivering services duplicative of care management must notify Vaya within 45 days of a member transitioning into or out of the service.

HIGH-FIDELITY WRAPAROUND (HFW) PROVIDERS

High-Fidelity Wraparound providers must facilitate timely communication across the care team. If a member meets the HFW eligibility criteria and elects to participate, the member will be transitioned from TCM to HFW services. The assigned TCM provider facilitates a warm handoff to the HFW team, at which time Vaya will disenroll the member from TCM. All providers offering HFW must meet fidelity requirements, as assessed by the NCDHHS vendor performing fidelity monitoring, as well as all requirements documented in the Department's HFW policy, including staffing, qualifications, and training requirements. Vaya reassigns members to TCM once they have completed the HFW intervention, unless the member opts out. Vaya gives preference to the provider organization delivered HFW if that provider is certified as a CMA and has the capacity to serve the member.

MEMBERS RECEIVING ACT OR RESIDING IN AN ICF/IID OR NURSING FACILITY

For members receiving ACT or residing in an ICF/IID or nursing facility for 90 days or longer, Vaya will:

- Ensure members engaged in TCM prior to obtaining ACT receive transitional care management in their first month of ACT services and assign the member to a TCM provider to receive transitional care management during the member's last month of ACT services
- Ensure members engaged in TCM prior to obtaining ICF/IID services receive transitional care management in their first month of ICF/IID services and assign the member to a TCM provider to receive transitional care management during the member's last month of ICF/IID services
- Ensure members engaged in TCM prior to obtaining nursing facility services receive transitional care management in their first month of nursing facility services; ensure members who are eligible for TCM and part of a priority population are assigned to a TCM provider and receive transitional care management during the member's last of month of nursing services; and, for members with behavioral health needs but who are not eligible for TCM or not part of a priority population, ensure the member receives care coordination for a behavioral health transitional care need in the last month of nursing facility services
- Suspend enrollment in TCM effective the month following initial receipt of ACT or ICF/IID services and report the suspension to NCDHHS
- Deny claims submitted by providers for TCM except in the first or last month of the member obtaining ACT or residing in an ICF/IID or nursing facility
- Ensure when a member begins obtaining ACT or ICF/IID or nursing facility services, their TCM care manager shares the member's person-centered plan or care plan (ISP) with the ACT, ICF/IID, or nursing facility case manager, as lawful with consent

TCM functions may be provided by a behavioral health clinician who specializes in the needs of members with mental health, substance use disorder, and/or I/DD diagnoses; qualified professionals (QPs) with mental health, substance use disorder, and/or I/DD specialties; registered nurse (RN) care managers who specialize in medically complex or medically fragile service needs; I/DD QP care managers; and/or certified peer support specialists (PSS). Care managers may directly perform an identified task or follow up to ensure tasks are completed by a member of the interdisciplinary, multisystem. And support care team (ICT), which includes the behavioral health provider. Care decisions are driven by what is best for the member based on ethical and best practice, not the convenience of the provider or caregiver/LRP. Vaya's care management practices include, but are not limited to, assessment, person-centered plan or care plan (ISP) development, crisis plan development, tasks and interventions, referral and linkage, risk and disease management, and monitoring. TCM processes also address the following:

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

Vaya Care Management Teams

Team	Description
TCM Mental Health/ Substance Use Care Managers	This team serves members with significant behavioral health needs who are assigned to Vaya for TCM and operates under a person-centered, recovery-focused model to help members who may need health and social support. The team's care managers ensure an integrated, whole-person care approach and foster coordination and collaboration among care team members across disciplines and settings.

Team	Description
TCM I/DD Care Managers	This team serves members with I/DD who are assigned to Vaya for TCM and operates under a person-centered model to help members who may need health and social support. The team's care managers ensure an integrated, whole-person care approach and foster coordination and collaboration among care team members across disciplines and settings. I/DD care managers also perform the following care coordination activities in accordance with NC Innovations Waiver requirements: (1) assisting in the development of a care plan for Innovations Waiver participants; (2) monitoring the provision of services to the member; and (3) ensuring the member's health and safety needs are met, that services and supports are provided in the most integrated setting, and that the member is satisfied with the services and supports they are receiving.
TCM RN and Medical Assistant (MA) Staff	RN staff host routine huddles for the clinical pods that serve as a clinical staffing model to provide consultation to priority members. Priority members receive RN clinical evaluation, plus pharmacist and medical doctor consultations, based on specific factors determined by Vaya's medical team. The RN role within the member's care team shifts based on the member's needs, and the RN may play a more prominent role following medical or psychiatric inpatient hospitalization, then step into a more consultative role supporting the identified primary care manager. MA staff provide additional support for integrated care coordination efforts.
Acute Transitional Care Managers and Admission Through Discharge Managers	This team provides on-site transition planning from psychiatric and medical inpatient settings for Vaya members, ensuring coordination with both Vaya's community-based TCM Care Management teams and community services and supports. Team members are embedded in private community hospitals, EDs, and DSOHF sites. The teams consists of RNs, licensed behavioral health clinicians, and QPs to support member transitions and partner with care managers/transitional care managers.
1915(i) and Complex Care Coordinators	Vaya maintains dedicated care coordinators for members receiving 1915(i) services. Additionally, our complex care coordinators serve members ineligible for TCM.

SECTION 5
Provider Responsibilities

Provider Preventable Conditions

Section 2702 of the Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act) prohibits federal payments to states under section 1903 of the Social Security Act for any amounts paid for providing medical assistance for health care-acquired conditions (HCACs). The statute prohibits states from paying for any HCAC. On June 30, 2011, CMS published a final rule implementing the requirements of Section 2702. The final rule requires that states implement non-payment polices for provider preventable conditions (PPCs), including HCACs. All providers who submit claims for payment of services to Vaya must comply with 42 C.F.R. § 438.3(g), which mandates provider identification of PPCs as a condition of payment, as well as the prohibition against payment for PPCs as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. Providers are required to monitor for PPCs and to report findings quarterly in a format determined by NCDHHS.

Records Retention

In addition to applicable documentation and records requirements found in federal and state laws, rules, and regulations, the NC Medicaid State Plan, NC Medicaid CCPs, and the Division of MHDDSUS State Service Definitions, all network providers must follow the Division of MHDDSUS Provider Agency Records Retention and Disposition Manual (APSM-10-5) for record retention and disposition requirements.

Network providers must retain the original service records of adult members/recipients for 11 years after the date of the last encounter. Service records of members/recipients who are minors and who are no longer receiving services must be retained for 12 years after the minor has reached the age of majority (age 18). 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 have met the required retention period. Following the conclusion of any investigation, audit, or legal action, the records may be destroyed if they meet the retention period in the schedule. Otherwise, they must be kept for the remaining time period. Upon expiration of the retention period, records must be securely disposed of, such as by shredding by a HIPAA-compliant vendor.

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

Documentation and Clinical Coverage Policy Requirements

All Vaya network providers are required to strictly adhere to the documentation requirements outlined in the Division of MHDDSUS Records Management and Documentation Manual, APSM 45-2 (the RMDM). Medicaid service provision requirements are specified in NC Medicaid CCPs, which include documentation, training, and other requirements. Each provider is responsible for knowing and following CCP requirements. Unfortunately, Vaya monitoring activities have identified non-compliance trends of with respect to the items listed below. Please ensure you and your staff understand and comply with the requirements applicable to your delivery of services.

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

Compliance

This section provides a high-level overview of your compliance requirements as a Vaya network provider. It is not intended to summarize every legal standard that applies to providers of Medicaid and/or other publicly funded health care services. You are required under your contract with Vaya to be familiar with all federal and state laws, rules, regulations, and payor program requirements applicable to your provision of services, including, but not limited to, the following laws, rules and regulations, as amended from time to time (referred to in your contract as Controlling Authority):

- Title XIX of the Social Security Act (the Act) and its implementing regulations, including those set forth at 42 CFR Parts 438, 441, 455, and 456 concerning care coordination, access to care, utilization review, clinical studies, utilization management, care management, quality management and disclosure requirements
- The NC Medicaid State Plan
- The NC combined Medicaid Waiver authorized by CMS pursuant to sections 1915(b) and 1915(c) of the Act

- All federal and state civil and criminal laws, rules, and regulations governing the provision of publicly funded health care services
- The Anti-Kickback Law codified at 42 U.S.C. § 1320a-7b(b) and its implementing regulations
- The Ethics in Patient Referral Act, 42 U.S.C. § 1395nn and its implementing regulations (applicable only to physicians)
- The federal False Claims Act, 31 U.S.C. §§ 3729 – 3733 and its implementing regulations
- The NC 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/recipient rights and confidentiality laws, rules, and regulations, including, but not limited to:
    - N.C.G.S. §§ 122C-52 through 56
    - The NC Identity Theft Protection Act, N.C.G.S. §§ 75-61 et seq.
    - The Division of MHDDSUS Client Rights Rules in Community Mental Health, Developmental Disabilities, and Substance Abuse Services, APSM 95-2
    - The Division of MHDDSUS Confidentiality Rules, APSM 45-1
    - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations at 45 CFR Parts 160, 162, and 164
    - Confidentiality of Substance Use Disorder Patient Records laws and regulations codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2
- Medical and/or clinical coverage policies promulgated by NCDHHS in accordance with N.C.G.S. § 108A-54.2
- The Americans with Disabilities Act of 1990
- Titles VI and VII of the Civil Rights Act of 1964
- Section 503 and 504 of the Vocational Rehabilitation Act of 1973
- The Age Discrimination Act of 1975
- The Drug Free Workplace Act of 1988
- State licensure, accreditation, and certification laws, rules, and regulations applicable to your operations
- Division of MHDDSUS Rules for MH/DD/SA Facilities and Services, published as APSM 30-1 and codified at Title 10A of the North Carolina Administrative Code
- Division of MHDDSAS Records Management and Documentation Manual, APSM 45-2
- The Record Retention and Disposition Schedule for Division of MHDDSUS Provider Agencies, APSM 10-5
- The Records Retention and Disposition Schedule for State and Area Facilities, APSM 10-3
- The NCDHHS Records Retention and Disposition Schedule for Grants
- This Vaya Health Provider Operations Manual
- Any other applicable federal or state laws, rules, or regulations in effect at the time services are rendered to Vaya plan members

COMPLIANCE PROGRAM

The Patient Protection and Affordable Care Act requires all health care providers to establish and implement a compliance program that meets the requirements of 42 C.F.R. § 438.608, as well as policies and procedures that meet the requirements of the Deficit Reduction Act of 2005. 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 program fraud and abuse by employees and members/recipients 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 who accepts public funding, please refer to the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG) Compliance Resource Portal webpage.

Vaya develops and maintains a written Compliance Plan that is reviewed and approved annually by the Vaya Board of Directors. Vaya's designated compliance officer and Regulatory Compliance Committee are accountable to senior management, and Vaya has documented 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.

Disaster and Emergency Relief Planning and Response

If a disaster or emergency results in a major failure or disruption in care (including, but not limited to, fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or an epidemic or pandemic), Vaya will collaborate with state and local emergency management agencies or other appropriate lead agency to coordinate local responders to deliver disaster response services to survivors and other responders within the Vaya region or statewide as requested by the State Disaster Response Team.

Vaya's community disaster response coordinator participates in the development of community disaster emergency response plans, collaborates with other state vendors to align efforts, promotes recruitment and training of Medicaid and State-funded services providers to staff disaster shelters, and responds to resource requests from the Division of Emergency Management within the North Carolina Department of Public Safety. Upon notification and activation of a community disaster, if needed, the Vice President of BH and I/DD Provider Network Operations or designee will begin coordination and engagement activities with local providers.

Vaya requires all network providers to have a disaster response plan that addresses the following elements:

- Meets the provider organization's accrediting body's standards;
- Identifies a disaster coordinator;
- Identifies disaster responders within the organization;
- Identifies training requirements for both the coordinator and the individual disaster responders;

- Identifies a contingency plan for member/recipient services where needed (e.g., medication supplies, housing); and
- If a residential provider, includes a member/recipient relocation plan.

Vaya complies with all NCDHHS guidance, including guidance on provider payments. This includes any need for advanced payment arrangements to support providers in the event of provider revenue disruptions. When directed by NCDHHS, Vaya will ensure continuity of Medicaid and State-funded services by:

- Offering extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries;
- Removing and/or reducing required authorizations and concurrent review of Medicaid and State-funded services;
- Ensuring emergency physical health services are accessible to Medicaid members and behavioral health services to Medicaid members and State-funded services recipients residing in shelters;
- Providing all members/recipients with access to out-of-network and telehealth providers if an appropriate participating provider is unavailable to treat them; and
- Increasing Medicaid Tailored Plan member access to medications by removing maximum dosage limits for required medication, including medication-assisted treatment (MAT), antipsychotics, and insulin.

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 than the general child population for potential abuse, neglect, and/or exploitation. Adults with disabilities may also be more vulnerable to abuse, neglect, and exploitation. County DSS agencies receive and evaluate reports to determine whether children and disabled adults need protective services. Income is not a factor in the protective services process. North Carolina mandates reporting of suspected child abuse or neglect or suspected abuse, neglect, or exploitation of disabled adults through separate statutes.

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

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

Provider Exploitation and Boundary Issues

10A NCAC 27C .0102 defines exploitation as the "use of a client's person or property for another's profit or advantage." In keeping with this definition, Vaya considers provider exploitation to be the illegal or improper act of using a Vaya member/recipient or their resources for monetary or personal benefit, profit, or gain, by a

network provider (including its owners, employees, agents, or contractors). Examples include, but are not limited to:

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

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

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

Vaya recognizes that the vast majority of network providers are dedicated, caring, and principled people who would never knowingly exploit or confuse Vaya members/recipients. Vaya expects network providers to use good judgment, consistent with current ethical standards and licensure rules, to make appropriate decisions that avoid the potential for exploitation or boundary confusion.

NOTE: Information in this section was adapted from "Managing Boundaries and Dual Relationships" by Frederic G. Reamer, PhD, March 4, 2002, *Social Work Today*.

Health Information Technology and Security

The provision of quality services often relies on the use of electronic health records (EHRs), rather than paper medical records, to maintain people's health information, as well as other systems that involve information technology (IT). Health IT makes it possible for providers to better manage care through the secure use and sharing of health information. As our system shifts toward integrated, whole-person care, health IT has become even more important. For more information, refer to healthit.gov.

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

- Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the information;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- 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, please refer to the U.S. HHS Summary of the HIPAA Security Rule webpage and Breach Notification Rule webpage.

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

ELECTRONIC VISIT VERIFICATION

In compliance with Section 12006 of the 21st Century Cures Act (the Cures Act), P.L. 114-255 was added to Section 1903(l) of the Social Security Act (SSA). Section 1903(l) is a federal requirement that requires use of an electronic visit verification (EVV) system for Personal Care Services (PCS) and Home Health Services (HHS) that require an in-home visit by a provider for states participating in the Medicaid program. Programs subject to the EVV requirement include in-home PCS, CAP/C, CAP/DA, self-directed personal attendant care services, and services provided through the Innovations, TBI, and 1115 Managed Care Demonstration waivers.

EVV systems use technology to record and confirm information about service delivery. This technology uses time, date, and location information from a cell phone, a home phone (landline), or an electronic fob to verify Medicaid services that are authorized and reimbursed by Vaya were actually delivered to members.

Vaya, along with all other North Carolina LME/MCOs, uses HHAeXchange as our EVV vendor. For current LME/MCO-covered services, EVV requirements apply to Community Living and Supports (CLS) and Supported Living-Periodic provided under the Innovations Waiver and the following 1915(i) Waiver services: Individual and Transitional Support, CLS Group, and CLS Individual.

Vaya uses EVV to collect the following data as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the Cures Act, 114 U.S.C. § 255:

- Type of service performed
- Individual receiving the service
- Date of the service
- Time the service begins
- Location of service delivery
- Individual providing the service
- Time the service ends

Health Information Exchange

Housed within the NC Department of Information Technology's (DIT) Government Data Analytics Center (GDAC), the NC Health Information Exchange Authority (NC HIEA) operates North Carolina's statewide health information exchange, NC HealthConnex. NC HealthConnex is a secure, standardized electronic system that allows providers to share important patient health information. The use of this system promotes the access, exchange, and analysis of health information and enables participating organizations to save time, reduce paperwork, facilitate more informed treatment decision-making, and improve health data analytics. Ultimately, the use of the HIE is designed to lead to improved care coordination, higher quality of care, and better health outcomes across the state.

Under state law, certain providers "are not required to connect to the HIE Network or submit data but may connect to the HIE Network and submit data voluntarily," including:

1. Community-based Long-term Services and Supports providers, including Personal Care Services, private-duty nursing, home health, and hospice care providers
2. I/DD services and supports providers, such as Day Supports and Supported Living providers
3. Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers
4. Eye and vision services providers
5. Speech, language, and hearing services providers
6. Occupational and physical therapy providers
7. Durable medical equipment (DME) providers
8. Non-emergency medical transportation (NEMT) providers
9. Ambulance (emergency medical transportation service) providers
10. Local education agencies (LEAs) and school-based health providers

Except as otherwise provided in the legislation, all other providers of Medicaid and State-funded health care services were required to be connected to and submitting demographic and clinical data to the HIE by June 1, 2020. For more information, refer to the NC HIE website.

Emergency Services and Hospital Requirements

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

EMERGENCY AND CRISIS STABILIZATION SERVICES

Vaya provides reimbursement for emergency and crisis stabilization services for eligible Medicaid beneficiaries at any time, without regard to prior authorization or whether the provider is contracted with Vaya.

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

Crisis stabilization or "post-stabilization care" services generally mean covered inpatient and outpatient services that are provided to maintain the stabilized emergency medical condition. Requests for reimbursement for emergency services must be presented to Vaya within 180 days of treatment or discharge (whichever is later). We will not require you to enter into a contract for reimbursement, but we will ask you to complete a billing enrollment form to obtain information required for our financial records. **You may not bill Medicaid members (or otherwise hold them liable for payment) for screening and treatment that was needed to diagnose an emergency medical condition or to stabilize the individual.**

If the individual was not enrolled with Vaya at the time-of-service delivery but is eligible for a Vaya health plan, Vaya will enroll them as soon as possible. The date of enrollment will be the date the emergency or post-stabilization care services were provided. However, individuals must be enrolled in our system before they can receive additional, non-crisis services.

NOTIFICATION OF ED ADMISSION FOR BEHAVIORAL HEALTH CRISIS

If an individual enrolled in 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 their designated Vaya point of contact and/or by calling the Provider Support Service Line at 1-866-990-9712. The hospital ED or facility where the individual is receiving treatment is ultimately responsible for assessment and disposition of individuals in their care. However, Vaya's Acute Transitional Care Team is available to provide ED and FBC staff with consultation, coordination with the individual's BHCH and education on possible resources for appropriate treatment.

You must allow Vaya care managers and hospital liaisons access to Vaya members/recipients 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 individual has a treatment relationship with a Vaya network provider, you must allow that provider access to the member/recipient while in the ED or FBC to help facilitate diversion from inpatient care.

You must notify Vaya within 24 hours when a Vaya member/recipient is discharged from the ED or FBC. If an individual who presented to the ED or FBC with a behavioral health issue is discharged, you must arrange for a follow-up appointment to occur within five business days of discharge with the individual's BHCH, or, if there is no BHCH, with an appropriate outpatient or other behavioral health provider. Vaya Member and Recipient Services staff can help arrange the follow-up appointment for members/recipients who are not yet connected with services. Please call the Member and Recipient Service Line 1-800-962-9003 for assistance with appointments.

INPATIENT ADMISSION NOTIFICATION AND AUTHORIZATION OF STAY

Behavioral Health Admissions:

Vaya honors a "pass through" for inpatient psychiatric treatment. For more information, refer to the Authorization Guidelines on our Provider Central website. However, Vaya reserves 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 inpatient treatment was not medically necessary or not delivered in accordance with all requirements of the Controlling Authority listed in your contract or OON Agreement, including, but not limited to, NC Medicaid CCP No. 8B.

Regardless of the pass-through period, you must notify Vaya within 48 hours of any behavioral health inpatient admission of a Vaya member/recipient so we can immediately link them to a community-based provider or work with their existing provider on discharge planning. Effective discharge planning is critical to reduce the cycle of readmission for some individuals with serious and persistent mental illness. **You must notify us of an inpatient admission within 48 hours by electronically submitting a SAR to the Provider Portal.** Vaya reserves the right to deny authorization and reimbursement of the initial pass-through period if you fail to notify us of the individual's admission within this timeframe.

Certification for continued hospitalization or services include the number of extended days or units or service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services. Requests for continued stay must be submitted electronically via the Provider Portal. The following information must be included in SARs: original admission information (including category of disability and diagnostic profile), reasons for requesting continued stay (including current risk factors and medical necessity criteria), current medications, name of attending physician, anticipated discharge date, and plan that notes step-down services and discharge living arrangement. For members with primary diagnoses of substance use disorder, 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 urine drug screens. You must also attach the Regional 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 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.

All Other Admissions:

Acute inpatient hospital admissions do not require prior authorization. If a member is going to receive a service or procedure during the hospital stay that requires prior authorization per NC Medicaid clinical coverage policies, hospital personnel must determine if the physician has an approved SAR before admitting the member. Nursing facility admissions for Medicaid members require prior authorization.

CRITERION V REVIEWS

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

RETROSPECTIVE AUTHORIZATION

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

Vaya Health
Attn: Inpatient Review Team
200 Ridgefield Court, Suite 218
Asheville, NC 28806

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

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

Involuntary Commitment

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

INVOLUNTARY COMMITMENT PROCESS

If the BHCH or first responder is unable to mitigate a crisis, and the individual is a danger to the self or others, yet is not willing to seek stabilization voluntarily, you are responsible for initiating an involuntary commitment (IVC) petition. The affidavit and petition form are available on the NC Administrative Office of the Courts website.

Who can file a petition for involuntary commitment?

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

What are the criteria for involuntary commitment?

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

What should the petition include?

The petition must contain facts to support the petitioner's belief that the individual (referred to as the "respondent") meets criteria for commitment, including evidence of significant history of harm to the 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 individual once located (e.g., hospital ED, FBC center, other IVC-designated facility, etc.).

Where, how, and when is the petition filed?

Every county has its own procedure, so it is important to check with the clerk of court's office where the petition will 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 on the NC Administrative Office of the Courts website.

What happens if the IVC petition is accepted?

If the magistrate or clerk of court agrees the petition meets criteria for involuntary commitment, they 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 who has been certified through a rigorous process – LCSW, LCAS (with limitations), or psychiatric NP. The first evaluator can do one of the following: (1) Stop the process and release the respondent if they determine the individual does not meet IVC criteria; (2) recommend inpatient mental health commitment; (3) recommend outpatient mental health commitment; or (4) recommend substance use commitment (called substance abuse, or SA, commitment in North Carolina).

If recommending SA commitment, the first evaluator can release the respondent pending a hearing and refer them to an outpatient provider, or the first evaluator can hold the respondent at a 24-hour facility pending a court hearing (a 24-hour treatment facility must be named on the form and accept the respondent). The decision to release or recommend outpatient mental health 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 for care and treatment. If a 24-hour facility is not immediately available OR appropriate to the respondent's medical condition, the respondent can be temporarily detained under appropriate supervision at the site of the first evaluation for up to seven days from issuance of custody order **OR** be released upon further examination by a physician, psychiatrist, or eligible psychologist:

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

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

What happens when a 24-hour facility is identified?

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

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

If the respondent is released, they are returned home via law enforcement or may arrange their own transportation. **Network providers may not decline inpatient behavioral health admission based on an individual's transportation options post-discharge.**

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

The 24-hour facility sends the petition and paperwork to the clerk of court in the county where the facility is located. A District Court hearing must be held within 10 days of an individual being taken into custody by law enforcement.

If the court finds by clear, cogent, and convincing evidence that the individual meets inpatient mental health commitment criteria, it may order inpatient commitment for up to 90 days at the initial hearing, a maximum of 180 days at the first rehearing, and a maximum 365 days at second or subsequent rehearing. Commitment can be inpatient, outpatient, or a combination of the two.

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

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

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

- The first evaluator must complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment Form, check all appropriate OPC boxes in all sections, and identify the name and address of the proposed outpatient treatment provider using Form 572.

- The first evaluator must also give the respondent 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 respondent 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).
- The proposed provider's medical doctor or licensed psychologist must complete another examination to determine if the respondent continues to meet the criteria for OPC.
- If the respondent is still in need of an OPC, the proposed provider's medical doctor, licensed psychologist, or designated clinician will attend the OPC hearing, where the judge will decide whether to continue the OPC. In some instances, the judge may order the examining medical doctor or licensed psychologist to provide face-to-face testimony at the OPC hearing. This OPC hearing is held within 10 days of the initial medical doctor's evaluation.
- If the respondent appears for the follow-up examination appointment and no longer meets the criteria for OPC, the medical doctor or licensed psychologist should complete the Notice of Commitment Change Form and send to the clerk of court, with a copy to the assigned Vaya care manager. This form is available on the NCDHHS website.

OUTPATIENT COMMITMENT RESPONSIBILITIES

OPC can be ordered for individuals who are deemed mentally ill; capable of surviving safely in the community with available supervision from family, friends, or others; in need of treatment to prevent further deterioration; and whose current mental illness limits or negates the ability of the individual to make an informed decision to seek voluntary treatment or comply with recommended treatment. Failure to comply with an OPC order may result in an order to law enforcement to take the individual into custody and present him or her to an inpatient facility for an evaluation. Vaya ensures the availability of qualified providers of services for members/recipients who are respondents to OPC proceedings and meet OPC criteria. Vaya accepts a copy of the OPC order for individuals who are served by network outpatient treatment physicians and centers and ensures providers serving members on OPC have a copy of the OPC order.

Individuals placed on OPC are likely to display high-risk behaviors and pose concerns regarding treatment compliance. The goal is to ensure a strong effort is made to provide appropriate follow-up for these individuals. Vaya requires network providers to meet the requirements detailed below for individuals on OPC. However, please be aware that in some counties, certain magistrates and clerks of court have developed specific procedures and workflows for working with OPCs. Network providers are responsible for adhering to established procedures and workflows applicable to the county where the OPC was issued.

Vaya requires network providers of services delivered pursuant to an OPC order to notify Vaya of the order immediately upon receipt. Once notified, Vaya refers the individual to care management services.

Network providers serving members under an OPC order must perform a face-to-face assessment within five working days of notification of the order, followed by ongoing outpatient face-to-face assessment and follow-up

treatment at the level clinically appropriate to the individual's needs and condition. Some individuals may need daily contact, while others may need weekly contact. No individual shall be seen less than once every two weeks unless they are in a supervised, 24-hour setting (e.g., family care home [FCH], group home) and are stable. If the provider determines the individual can be seen less than bi-weekly (two times per month), a medical doctor, licensed psychologist, family NP (FNP), or physician assistant 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 the individual no longer meets criteria to continue the OPC, the physician, licensed psychologist/FNP, or physician assistant 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 care manager, who will log the termination of commitment. If the individual was initially committed due to conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and was found incapable to proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the clerk of court's office for clarification.

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

If the individual clearly refuses and fails to adhere to all or part of the prescribed treatment, while continuing to meet commitment criteria, you should make all reasonable efforts to engage their 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. You must also send a copy to the assigned care manager.

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

If the individual fails to comply but does not clearly refuse to comply (e.g., the individual has a pattern of scheduling appointments but does not show up), you may request the court to order the taken into custody for the purpose of a face-to-face evaluation. This option is only available if you know where the individual can be located. To do this, you must complete a Request for Transportation Order and AOC-SP-220. It must be sent to the clerk of court where the commitment is being supervised, with a copy sent to the assigned care manager.

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

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

- First, you must be able to demonstrate supporting documentation and/or billing for at least one of the following **within 72 hours (excluding weekends/official Vaya holidays)** of the initial missed appointment:
    - A face-to-face visit in the individual's home
    - A rescheduled office appointment with the clinician that the individual attends
    - A phone conversation with the individual about the services being offered
    - At least one face-to-face attempt to contact the individual at their last known address
    - A follow-up letter sent to the individual at their last known address
- Second, assuming the above-listed attempts to locate the individual are unsuccessful, you must attempt face-to-face contact once per week for the first two weeks, then one more attempt two weeks later (the fourth week).

- If the individual's last known address is a homeless shelter, or someone else who resides at the last known address states the individual 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 individual's location must also be pursued.

What if these reasonable professional efforts are unsuccessful?

You must document the efforts made (including three attempts at face-to-face contact over a four-week period) in a letter to the clerk of court's office in the supervising county, complete a Notice of Commitment Change and send the form to the clerk of court, with a copy sent to the assigned care manager. Remember that if the initial commitment was due to conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and the individual was found incapable to proceed (ITP), a hearing must be scheduled to make any changes to the commitment.

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

What is the review process for continuation of the OPC?

Prior to the expiration of the OPC, the network provider clinician must review the case with a physician, licensed psychologist, FNP, or PA and determine if the individual still meets the criteria for OPC and whether it needs to be extended. If the individual has been compliant and no longer meets the criteria, the duration of the OPC will naturally expire. If you determine the individual continues to meet the OPC criteria and a rehearing is needed, then the physician/licensed psychologist must complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment, Form 5-72-09, available on the NCDHHS website. This form, along with a completed Request for Hearing Form, must be submitted to the clerk of court, with a copy sent to the assigned care manager.

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

If the individual moves to another state, you must document this change in the medical record, complete a Notice of Commitment Change and send it to the clerk of court's office, with a copy sent to the assigned care manager. Remember that if the initial commitment was a due to conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and the individual was found incapable to proceed (ITP), a hearing must be scheduled to make any changes to 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 individual moves to another LME/MCO region?

If the individual plans to relocate to another county within the state that is outside of Vaya's region, you must request that the clerk of court in the county where the OPC is supervised schedule a hearing prior to the move. The physician/licensed psychologist must complete a new Examination and Recommendation to Determine Necessity for Involuntary Commitment and send it to the clerk of court's office with a completed Request for Hearing Form, with a copy sent to the assigned care manager.

What if the individual relocates to another county within Vaya's region?

If the individual plans to move to a new county and receive services from a new provider, the original provider must connect the individual to a new provider. The original provider's OPC responsibilities do not end until the new provider accepts the individual for services. If the individual is moving to a new county, but staying with the same provider organization, the current provider must arrange for all necessary transitions 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 individual wants to change providers?

If the individual wants to receive services from a different network provider, the original provider must connect them to a new provider. The original provider's OPC responsibilities do not end until they confirm the new provider has accepted the individual for services.

Substance Abuse (SA) Commitment

Involuntary SA commitments generally take a great deal of coordination among community-based outpatient providers (e.g., SAIOP, SACOT) and potential inpatient treating facilities (state Alcohol and Drug Abuse Treatment Facilities, local FBC 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, a re-hearing must be held.

At this hearing, 90 days can be ordered inpatient. Individuals under SA commitment who do not comply with treatment can be picked up by law enforcement, evaluated in the community, and admitted to a 24-hour treatment facility if inpatient criteria are met (without a new petition). In such cases, the network provider must complete a Request for Transportation Order and Order (Committed Substance Abuser Fails to Comply with Treatment or is Discharged from 24-Hour Facility) AOC-SP-223 and submit it to the clerk of court's office, with a copy sent to the assigned care manager.

Once the pick-up order is issued, the individual 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 the individual 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.

Crisis Prevention/Response

THE CRISIS SERVICES CONTINUUM

A strong continuum of services is available to help support and stabilize Vaya members and recipients in crisis. Crisis services include Mobile Crisis Management (MCM), FBC center, non-hospital detoxification, walk-in crisis, NC Systematic Therapeutic Assessment, Respite, and Treatment (NC START), or use of a hospital ED for reasons related to mental health or substance use disorders. Network providers must be aware of available crisis resources, how to access them, and how to use services according to the nature of the individual's crisis, as well as understand your role and responsibilities within the crisis continuum. Vaya contracts with multiple MCM teams to provide coverage for all counties in our region. In each county we serve, we support walk-in centers that are operated by contracted comprehensive care providers, where members and recipients can go to receive same-

day assessment and treatment. Additionally, multiple FBC centers serve the Vaya region. As discussed below, basic benefit providers of behavioral health, I/DD, and TBI services may use MCM for face-to-face assessment and intervention if the provider's phone response does not reduce the crisis.

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

COMPREHENSIVE CRISIS PLAN DEVELOPMENT

Vaya requires all behavioral health, I/DD, and TBI network providers to develop Comprehensive Crisis Plans (CCPs) for members/recipients they serve as part of the person-centered planning process. In addition, all behavioral health, I/DD, and TBI network providers must follow the state's Comprehensive Crisis Intervention and Prevention Plan guidance. The CCP must be created with input and participation from the individual and natural supports and include provider and support person contact information, prevention, and early intervention strategies for the individual to use and must include member/recipient-identified strategies for use by professionals if the individual needs to access crisis services. It is designed to be one section of a person-centered plan or care plan that can be easily extracted as a stand-alone document for ease of distribution.

Who is required to have a Comprehensive Crisis Plan?

Network providers of behavioral health, I/DD, and TBI services MUST ensure that ALL individuals with person-centered plans also have completed CCP and Intervention Plans. In addition, all individuals who are at significant risk of crisis events – including those receiving only basic benefit services – must have a CCP in place. This includes individuals who have received inpatient psychiatric or substance use treatment, been arrested, attempted suicide, or used crisis services within the past year.

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

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

How and when is the CCP updated and shared?

Individuals receiving services must receive a copy of the plan and all pertinent crisis contact/after-hours numbers to use in an emergency. CCPs are "living documents" and must be reviewed and updated as needed. Plans are required to be updated annually and whenever a member's medications or natural supports change or another significant change occurs that impacts crisis planning. CCPs should be reviewed after every crisis event (such as using MCM or receiving behavioral health ED or inpatient treatment) and updated as needed. Where permitted under applicable privacy laws, Vaya may share an individual's CCP with an ED or a MCM provider to help alleviate

or respond to a crisis. For this reason, it is critical that CCPs be uploaded as soon as possible following completion of or any updates to the plan.

Members enrolled in TCM also have crisis plans with their care managers. See Section 4 for more information on the relationship between the care management crisis plan and provider's crisis plan.

Transition, Discharge, and Provider Closures

Network providers are required to refer members/recipients for specialty care or to other contracted providers in response to a member request, a change in member's level of care, or a change in the provider's status within the Vaya network. You must ensure continuity of care for individuals in such circumstances, limit potential disruption to services, and cooperate with all transition and discharge activities, including complying with all referral and documentation requirements.

MEMBER/RECIPIENT REQUEST

If a member/recipient requests to change providers, you must help them transition to the new provider of their choice. This includes giving them a list of alternate providers, making the new appointment or working with Vaya's Member and Recipient Services Department to obtain an appointment with the new provider, and sharing all health records necessary for continuity of care with the new provider as soon as possible. It is not acceptable to discourage a member/recipient from selecting a new provider or practitioner or to charge a fee for the transfer of medical records.

CHANGE IN LEVEL OF CARE

If you determine a member's/recipient's needs have changed and the current service or level of care you provide is no longer clinically appropriate, you must offer education and assistance about available options and best practices. Once a new service and/or provider is identified, you must help the individual transition to the new provider of their 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 more appropriate service or level of care.

DISCHARGE FROM LICENSED FACILITIES

In accordance with N.C.G.S. § 122C-63, providers must notify the member/recipient and Vaya if they intend to close an I/DD residential facility or discharge an individual from an I/DD residential facility ***at least 60 days prior*** to the closing or discharge. Individuals living in other non-I/DD 24-hour licensed facilities, such as mental health group homes or ACHs, must be provided ***at least 30 days' notice*** prior to closure or discharge. These timeframes are necessary to protect continuity of care and give the individual time to find a new place to live. Vaya strictly enforces these timeframes and reports any violations to the NC Division of Health Service Regulation (DHSR).

VOLUNTARY PROVIDER CLOSURE

Network providers are required to notify Vaya 60 days in advance of a voluntary closure of a site, service, or regional or statewide business operations. The following information must be sent in writing to provider.info@vayahealth.com or your assigned provider network contract manager:

- Whether the entire organization is closing, or only a part of it, and which part(s) or site(s), as well as whether you are closing all operations in North Carolina

- The date of site closure, end of operations, or effective date of specific service elimination

Upon receipt of such notice, Vaya will send you a written confirmation of withdrawal from the network, confirming the effective date of your contract termination. In addition, you will receive instructions regarding member/recipient transition. The written notice will include a form you must complete to help us gather the following information:

- A list of the names and dates of birth of affected individuals and the services they currently receive (affected individuals include those seen by your organization within 60 days of the transition notification)
- Which notifications you made and when (e.g., to government agencies, members, other providers) and the notification method
- A list of individuals currently receiving medication management services, with prescription due dates (we strongly encourage you to issue 90-day prescriptions to individuals prior to closure or service termination, when medically appropriate)
- Whether you made arrangements to refer Vaya members/recipients to other providers
- Identity and contact information for the primary person at your organization responsible for coordinating member/recipient referrals
- A list of affected individuals and a written plan to transfer them to the receiving provider
- A list of credentialed practitioners who will no longer be employed by you, if applicable
- A list of employees who will continue to have access to Vaya software systems during the closing process and the date access should be terminated

For voluntary closures, you must send a written notification to members/recipients/LRPs advising of the closure, including the effective date, and immediately begin work to refer individuals to other providers. Vaya will also send a written notice to affected individuals/LRPs. This notification is not necessary if you did not provide any services to Vaya members/recipients and had no active service authorizations within the preceding 60 days.

INVOLUNTARY PROVIDER CLOSURE

If Vaya decides not to renew your contract, site, or service, or if we decide to terminate or suspend your contract, we will send you a written notice with instructions for member/recipient transition. It is not acceptable to interfere with or prevent a transition in such circumstances or to discourage the individual from transitioning to another provider. The notice will include a form you must complete and submit within five days of receipt to help us gather the following information:

- A list of the names and dates of birth of affected individuals and the services they currently receive
- A list of individuals currently receiving medication management services, with prescription due dates (we strongly encourage you to issue 90-day prescriptions to individuals prior to closure or service termination, when medically appropriate)
- Whether you made arrangements to refer Vaya members/recipients to other providers
- Identity and contact information for the primary person at your organization responsible for coordinating member/recipient referrals
- A list of affected individuals and a written plan to transfer them to the receiving provider
- A list of credentialed practitioners who will no longer be employed by you, if applicable
- A list of employees who will continue to have access to Vaya software systems during the closing process, and the date access should be terminated

For involuntary closures, Vaya will help with member/recipient referrals, but transition remains your primary responsibility. We will also send a written notice to affected individuals/LRPs explaining our decision and the transition process, including other provider choices available, if any.

Individuals receiving active treatment for acute or chronic behavioral health conditions may continue to receive services with the provider through the period of active treatment, or for 90 calendar days after the closure/change in services, whichever is less. The provider must notify Vaya's UM Team of individuals undergoing active treatment and the plan to transition them. For the UM Team authorize continuing services, you must agree to continue treatment for an appropriate duration based on the transition plan goals, share ongoing information about treatment plan progress with the UM Team, continue to follow UM policies and procedures, and charge only the required copay, if applicable.

Within 15 calendar days of notifying the provider of a contract termination, Vaya will provide written notice to all members and recipients who have received or are scheduled to receive services from the terminated provider within the six-month period immediately preceding the termination notice date, unless the terminated provider is a primary care provider (PCP), Advanced Medical Home Plus (AMH+), or Care Management Agency (CMA). In these cases, Vaya will provide the member the following information either within 30 calendar days prior to the termination effective date or seven calendar days after the receipt or issuance of a provider termination notice: procedures for selecting an alternative PCP, AMH+, or CMA; that the individual will be assigned to a PCP, AMH+, or CMA if they do not actively select one within 30 calendar days; and procedures for continuing to receive care from the terminated provider and extension limitations.

CLOSURE RESPONSIBILITIES

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

- If requested by the receiving provider, you must actively participate in treatment team, transition, and/or discharge planning meetings until such time as all individuals 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, or withdrawal.
- Regardless of the reason for closure, you are required to retain, or arrange for the retention of, all original service records. You must submit a written plan to maintain and store all records of services provided to Vaya members/recipients at least 30 days prior to your contract end date, as well as a reference list of records that includes the individual's name, service record number, date of birth, last date of service, and Medicaid number and county of Medicaid origin, if applicable.
- Records must be stored in an environment that ensures 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 records custodian, and their contact information.
- Vaya has the sole discretion to approve or disapprove any such plan. If the plan is not approved, we may require you to arrange for electronic or paper copies of records to be transferred to our possession within 15 days of the request. Even if Vaya or a receiving provider accepts such copies, you are still required to maintain the original records in a secure environment. You must provide a copy of the paper record storage log and

contact information for a staff person who will help Vaya take possession of the records. Records must be transferred in an organized, searchable format.

- Paper record storage logs must include the:
    - Provider name
    - Date of storage
    - Series/box number (e.g., box 1 of 3)
    - Start date and the end date of the box contents
    - Record type or the name of the individual. Record type refers to the classification of the information contained in the box. Please store records of the same type in the same box.
    - Record ID number or any other identifying number or information
    - Date of birth for individual service records. In the case of personnel records, the employee's date of birth should be recorded for quick reference.
    - Timeframe of the information stored in a particular box (e.g., an admission of 01/02/2009 – 09/13/2009 or an employment period of 02/12/2009 – 12/13/2009) or a specific timeframe (e.g., October 2002 Cost Reporting).
- All claims for services must be submitted within 60 days of contract non-renewal, termination, or withdrawal. Vaya will adjudicate claims on our published checkwrite schedule, unless we suspend your final payment to ensure compliance with all transfer and closure requirements outlined in this section:
    - If you fail to comply with member/recipient 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 our Legal 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 our Legal 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 remaining funds.

SECTION 6
Network Requirements

Non-discrimination Statement

Vaya has zero tolerance for unlawful discrimination or harassment of any kind. Vaya does not discriminate against members, recipients, providers, employees, or applicants in the provision of services or administration of any Vaya Health plan, including, but not limited to, any clinical, marketing, and care management programs offered by Vaya or its network providers to Vaya members and recipients. This policy applies to all aspects of subcontracting and network participation, including, but not limited to, selection and retention, contracting, utilization reviews, audits, monitoring and investigations, adverse actions, and dispute resolution. Furthermore, it is a violation of our contracts with contracted providers or subcontractors for them to engage in unlawful discrimination or harassment of any kind related to hiring or employment practices or in the administration or provision of services.

Discrimination in general means treating a person unfairly because of who they are or because they possess certain characteristics. Per Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C §2000d et seq., "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." Discrimination that occurs because of any characteristic protected by federal, state, or local law is unlawful and in direct violation of Vaya policy.

Vaya does not discriminate on the basis of any protected classification or characteristic, including, but not limited to, race, color, creed, religion, ancestry, sex, gender identity, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information, health status/need for health services, or National Guard, veteran's, marital, parental, or other protected status, in compliance with laws that prohibit discrimination. Vaya also does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment or against any provider who is providing a covered service and who is acting within the scope of their license or certification under applicable state law solely on the basis of practitioner or facility license or certification type.

Vaya provides the following to support effective communication with us:

- Free auxiliary aids and services to people with disabilities, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people who primarily speak a prevalent language in North Carolina other than English, such as:
    - Qualified interpreters
    - Information written in other languages

NON-DISCRIMINATION LAWS

Vaya complies with all applicable federal and state laws, rules, and regulations, guidelines, and standards, including those that may be lawfully adopted pursuant to the following laws and orders prohibiting discrimination:

- Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
- Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity, and national origin;
- Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;
- Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;
- The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;
- Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation, or beliefs;
- The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;
- Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;
- The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex, or handicap by employers that regularly employ 15 or more employees;
- The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;
- The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and
- The non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017, by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or veteran's status, sexual orientation, and gender identity or expression.

On-call Coverage

Vaya requires all network providers to maintain appropriate after-hours and emergency coverage and to respond in a timely, appropriate manner to any member/recipient who is in crisis**. 911 should never be the first line of contact for a 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 (BEHAVIORAL HEALTH, I/DD, AND TBI)

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

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

BHCH AND PROVIDERS OF ENHANCED SERVICES (BEHAVIORAL HEALTH, I/DD, AND TBI)

BHCHs and providers of enhanced services are required to have "first responder" capability for the people they serve, in accordance with the applicable NC Medicaid clinical coverage policy for the enhanced service being provided.

- All above stipulations for basic benefit providers also apply to BHCH and enhanced services providers.
- In addition, these providers must be available 24/7 to respond to individuals receiving services from them both telephonically and face-to-face for crisis response, as needed.
- BHCH and enhanced service providers (IIH, Multisystemic Therapy [MST], CST, ACT, Substance Abuse Intensive Outpatient Program [SAIOP], Substance Abuse Comprehensive Outpatient [SACOT]) must respond via face-to-face contact if telephone contact is not successful in mitigating the crisis.
- First responders are responsible for obtaining involuntary commitment (IVC) petitions, if necessary. See Section 5 of this manual for more information about the IVC process.

WHO AND WHAT ARE BHCH PROVIDERS?

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

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

Providers of the enhanced services below assume the BHCH and first responder functions for individuals immediately upon admission to the service: IIH, MST, CST, ACT, SAIOP, and SACOT.

Other BHCH providers may include providers of Day Treatment, Psychosocial Rehabilitation, and 24-hour residential treatment. Outpatient therapists assume clinical home functions if outpatient services are being delivered and none of the above services are a part of the individual's person-centered plan. If the individual is not connected with another provider upon discharge, the BHCH retains emergency response duties for 60 days post-discharge.

RELATIONSHIP BETWEEN FIRST RESPONDERS AND MOBILE CRISIS

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

MCM teams are required to promote effective linkages between I/DD crisis service providers by establishing and maintaining formal, written affiliation agreements. The agreements must be developed collaboratively between MCM providers and all I/DD crisis services providers in the region and outline the roles and responsibilities of both parties.

INNOVATIONS WAIVER PROVIDERS OF DIRECT CARE SERVICES

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

- Community Living and Supports
- Residential Support services
- Supported Living

Please note the following:

- Providers of the above-listed services must train members and their paid/unpaid supports in how to access the designated crisis responder. The designated crisis responder's contact information must be clearly outlined in the participant's care plan and be accessible in the participant's home setting or settings where they receive services.
- At a minimum, the provider must first assess by phone to determine if face-to-face support is needed. The assessment includes 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 thinks MCM is needed to assist with ED diversion.
- Members have the right to select another crisis response services provider from within Vaya's network.
- Care plan crisis plans must include mental health or medical health supports and their contact information. All providers listed on a crisis plan must know and understand their role in a crisis for that participant, including MCM. Crises can occur in the form of behavioral or medical needs.

DIRECT CARE PROVIDERS OF STATE-FUNDED I/DD SERVICES

Direct care providers of State-funded (non-Medicaid) I/DD services, such as Individual Habilitation/Personal Assistance, must also develop appropriate crisis plans for individuals they serve. Individuals and their support persons must be trained how to implement the plan, and all people/providers in the crisis plan must know and understand their role in crisis response.

Individuals with an I/DD who are not receiving services or linked to a provider should use MCM in a behavioral health crisis. Any eligible individual who is linked to MCM for emergency response will be connected with a provider for follow-up services as needed. Vaya's Member and Recipient Services Department can help link individuals you serve to an I/DD provider.

FREQUENTLY ASKED QUESTIONS

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

When several providers serve the same individual, the crisis plan should clearly outline who serves as first responder. During the crisis planning process, roles and contacts should be clearly defined and detailed in collaboration with the individual and their family, friends, or other natural supports.

What if the case is closed or transferred? Or the individual 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 help in a crisis. As a general rule, Vaya requires all providers to respond for an individual they have seen or treated in the previous 60 days. Until a new provider accepts the case and is seeing the individual is, the case is not officially transferred, and the original provider is in the best position to act as first responder. If a case is closed without referral to another service, and the individual experiences a crisis within 60 days, the provider must respond and use the crisis as an opportunity to evaluate and re-engage the individual.

When should an MCM team be called to respond to an individual in crisis?

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

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

The provider must be available to consult by phone with the ED. Often, this is all that is needed. However, if the provider determines the individual needs a higher level of care and has exhausted other alternatives (MCM, FBC, detox, crisis bed, etc.), the provider must accompany them to the ED and provide a warm hand-off, sharing clinical and resource information to help with 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 Individuals. A hospital physician may be more willing to consider diversion if the first responder is there and able to make specific arrangements for prompt and aggressive follow-up if the individual is not hospitalized.

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

Yes. Vaya network providers must share CCPs and person-centered plans with care managers to support continuity of care, both at the time of first signature and whenever revisions are made. Crisis plans must be updated when the person-centered plan is updated or when there is any significant change in functioning (e.g., a crisis event or hospitalization). As with any revision to the person-centered plan, a signature is required.

CRISIS PREVENTION AND EDUCATION EFFORTS

As a Vaya network provider, you must participate in crisis prevention and education efforts to minimize crises among the individuals you serve, reduce stigma, and educate the community about services you offer. These efforts should include, but are not limited to, crisis plan development and implementation; required after-hours response and first responder duties; local Crisis/Emergency Department Initiative (CEDI) committee activities; development of prevention, education, and outreach programs; and distribution of educational materials about behavioral health disorders, I/DD, and/or TBI. For crisis plans requirements for TCM participants, refer to Section 4 (Care Management) of this manual.

Provider Enrollment

IDENTIFICATION OF SERVICE NEEDS

Vaya is committed to supporting the fiscal stability of network providers. We consider applications from ***new*** applicants for behavioral health, I/DD, and TBI services if service capacity is not met (i.e., due to a demonstrated community or individual service need). If Vaya identifies and approves a specific service need as the result of the Network Access Plan for Medicaid or the Network Access Plan for State-funded Services analyses or based on an internal review, we may seek to add appropriate providers through various means, including direct provider contact, solicitation of applications via the Vaya Provider Communication Bulletin or website, or a procurement process.

Interested applicants first complete and submit a Provider Contract Request Form, available on our website. If the request is approved, the provider must complete or update all necessary information in NCTracks for processing for credentialing and enrollment as a Medicaid or State-funded services provider.

CENTRALIZED PROVIDER ENROLLMENT AND CREDENTIALING

NCDHHS is partnering with a designated Provider Data Management/Credential Verification Organization PDM/CVO to implement a centralized credentialing and re-credentialing process with the following features:

- NCDHHS, or the NCDHHS-designated vendor, collects information and verifies credentials through a centralized credentialing process for all providers currently enrolled or seeking to enroll in NC Medicaid.
- NCDHHS applies the credentialing policies to any providers who furnish, order, prescribe, refer, or certify eligibility for Medicaid, including all providers that must be credentialed under credentialing standards established by a nationally recognized accrediting body per 42 C.F.R. § 438.602(b).

- The process and information requirements meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization.
- Providers use a single, electronic application to submit information to be verified and screened to become a Medicaid-enrolled provider, with the application serving for enrollment as an NC Medicaid Direct provider and an NC Medicaid Managed Care provider.
- Providers are re-verified and re-credentialed every five years, except as otherwise specifically permitted by NCDHHS.

Vaya accepts provider credentialing and verification information from NCDHHS and will not request any additional credentialing information without NCDHHS approval. Vaya makes contracting determinations based solely upon the credentialing information and Objective Quality Standards provided by NCDHHS. Vaya also uses its Good Faith Provider Contracting Policy to decide whether to contract with a provider enrolled to provide Medicaid or State-funded Services. Vaya is prohibited from contracting with providers who are not enrolled with NCDHHS as NC Medicaid or State-funded services providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.

SELECTION (ENROLLMENT) CRITERIA FOR THE CLOSED NETWORK

To enroll as a new provider in Vaya's closed behavioral health, I/DD, and TBI network, providers must meet all the criteria below, as applicable to the provider type. These standards were established, in part, as a way to assess a provider's ability to deliver care. We specifically reserve the right to conduct an on-site review at any time to confirm compliance with these criteria and further reserve the right to reject any applicant 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 NCDHHS credentialing and/or re-credentialing requirements.
3. The applicant must be in good standing as defined in this manual.
4. The applicant must provide truthful, accurate information during the selection process, including in the enrollment and the NCDHHS-identified CVO 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/recipients and families.
7. The applicant must have a "no-reject" policy for referrals.
8. The applicant must have a robust Compliance Plan that meets the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
9. The applicant must have a Quality Management Plan with evidence of implementation of strategies and goals.
10. The applicant must have adequate clinical leadership according to the disability and services provided, with a sufficient supervision structure.
11. With limited exceptions, all applicants must have a HIPAA-compliant EHR system that supports management of authorizations and billing functions. EHRs must be able to send HL7 messages (versions 2 or higher) to communicate with the NC Health Information Exchange (HIE), NC HealthConnex. Vaya prefers applicants who demonstrate compliance with the Federal Meaningful Use Standards and who can comply with clinical reporting requests.

12. The applicant must demonstrate fiscal stability, based on the most recent annual audit or other financial indicators, and defined as having: (1) a minimum of one month's working capital or line of credit equal to the applicant's monthly gross income or revenue; and (2) no tax liens.
13. The applicant must have the business operations and information technology infrastructure in place to meet all clinical, quality improvement, billing, and confidentiality standards required for providers of publicly funded health care services, including, but not limited to, infrastructure to monitor all company financial information, such as debt-to-income ratio.

NETWORK PROVIDER CHANGE REQUESTS

Behavioral health, I/DD, and TBI 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 Contract Request Form, available on our website. If Vaya has not identified a need for the additional site or service, we may reject the request or gather information about service capacity and needs and present the request to leadership for consideration. We will inform you of our decision.

Network providers may enroll additional licensed practitioners without submitting an application, so long as these practitioners will work out of existing site locations contracted with Vaya. All credentialing activities are conducted by the NCDHHS-designated CVO, and all licensed practitioners are required to submit an application for credentialing to the CVO as outlined later in this section of the manual.

Existing network providers of Innovations Waiver services seeking to add an additional Innovations Waiver service to their contract to serve a specific participant must complete and submit the Provider Contract Request Form. Vaya bases determinations on such requests in part on information about whether the additional service is necessary to meet a specific need. If the request is for a residential service that requires additional credentialing, the provider must complete the credentialing process through the CVO. NC Medicaid guidelines require all new applicants seeking to provide Innovations Waiver services must be nationally accredited in I/DD service provision and meet all HCBS requirements.

BEHAVIORAL HEALTH, I/DD, AND TBI NETWORK PROVIDER RETENTION (RENEWAL) CRITERIA

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

In general, Vaya's policy is to renew network contracts unless one of the following applies: (1) renewal does not support the Comprehensive Care Center model as determined by Vaya; (2) renewal is not supported by the Network Adequacy and Accessibility Analysis, Network Access Plan, or a detailed Market Analysis as determined by Vaya; (3) public funds to support the service are not available (e.g., reduction in State or local funding); (4) there is excess capacity for any of the services offered by the provider as determined by Vaya; (5) Vaya issued an

RFP or RFI for the service(s) delivered by the provider; or (6) the 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 Medicaid State Plan, Medicaid waivers, Division of MHDDSUS State-funded Service Definitions, and/or NC Medicaid CCPs
    - Adherence to all medical necessity and documentation requirements as set forth in NC Medicaid CCPs, Division of MHDDSUS State-funded Service Definitions, and/or the RMDM
    - Cooperation and participation with all Vaya network integrity activities (including, but not limited to, audits, investigations, and post-payment reviews), and Vaya's process for utilization management, quality management, incident reporting, and member/recipient appeals and grievances/complaints.
- The provider has not billed for services in the 60 days prior to Vaya's review of the contract renewal, unless it concerns an out-of-network provider, out-of-area provider, or provider of specialty services that are delivered infrequently.
- The provider is not in good standing as defined in this manual.
- Vaya, NC Medicaid, or CMS determines the provider falsified information provided on documentation submitted for re-credentialing, screening, or enrollment in the Vaya network or NC Medicaid.
- Vaya issued three or more plans of correction against the provider for the same or similar out-of-compliance findings (e.g., three findings related to lack of training, even if it referred to different trainings), within a six-month period).
- Vaya identified quality-of-care concerns, Level II or III incidents, or other serious grievances about the provider that were not satisfactorily resolved within required timeframes.
- The provider has a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Vaya.
- The 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 provider fails to maintain and provide proof of insurance as required under the terms and conditions of the contract.
- The provider routinely fails to satisfactorily complete and upload SARs that meet Vaya UM requirements (i.e., a high percentage of administrative denials proportional to the number of members/recipients served; generally, anything higher than 10 percent is unacceptable).
- The provider routinely fails to submit requests for SARs for continuation of currently authorized services at least 14 days prior to end of existing authorization – at least 75 percent of SARs must meet this standard.
- The provider failed to implement an adequate emergency response system that complies with the requirements of contracted services, including measures to respond to emergencies on weekends and evenings for individuals currently served.
- The provider routinely fails to meet Division of MHDDSUS access standards and appointment wait times or fails to comply with the no-reject policy for members/recipients referred by Vaya.
- The 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 provider failed to cooperate and comply with discharge and transfer requirements to ensure a smooth transfer for any member/recipient that seeks to change providers or because the provider cannot meet their 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
- Efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes
- Member/recipient service and health literacy efforts to implement a system that ensures good communication with individuals and families
- Evidence of cooperation with, and level of participation in, member/recipient and provider satisfaction surveys
- Implementation of a robust Corporate Compliance Plan and Quality Management Plan, with evidence of implementation of strategies and goals
- Evidence of adequate clinical leadership according to the disability and services provided, with a sufficient supervision structure
- Efforts to implement a HIPAA-compliant EHR system that supports management of authorizations and billing functions. EHRs must be capable of sending HL7 messages (versions 2 or higher) to NC HealthConnex. Vaya prefers providers that demonstrate compliance with the Federal Meaningful Use Standards and can comply with clinical reporting requests.
- Demonstrated financial stability defined as having: (1) a minimum of one month's working capital or line of credit equal to the provider's monthly gross income; and (2) no tax liens
- Demonstrated operations and IT infrastructure in place necessary to meet all clinical, quality improvement, billing, and confidentiality standards required for providers of publicly funded health care services, including, but not limited to, infrastructure necessary to monitor all company financial information, such as debt to income ratio

Vaya may terminate a provider from the closed network with or without cause. If this occurs, Vaya will provide written notice of the termination to the provider that includes, at a minimum, the following:

- Reason for our decision;
- Effective date of the termination:
- The provider's right to appeal the decision; and
- How to request an appeal (please see Section 11 (Provider Disputes) of this manual for details).

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

GOOD STANDING

All applicants for enrollment in the Vaya provider network must be in good standing to be considered for initial enrollment or contract renewal. Good standing will be verified as part of the contract renewal processes as described earlier in this section of the manual. **We consider a provider to be in good standing if all following**

criteria are met (please note all activities associated with continuous verification of exclusion status are conducted by the CVO):

- 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.
- 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 NC Health Choice program, the Medicare program, or another Medicaid managed care program involuntarily terminated for any reason.
- The individual or entity and any owners, directors, and managing employees did not previously own, operate, or manage any provider entity that owes an outstanding overpayment to U.S. HHS, NCDHHS, Vaya or another LME/MCO.
- There are no current Medicare, or Medicaid fines or sanctions in effect against the individual or entity by CMS or its contractors, or any state Medicaid agency, including, but not limited to, contract termination or suspension, referral suspension, payment suspension, moratorium, placement on prepayment review, or similar actions.
- The individual or entity has an acceptable professional liability history, defined as no history of liability claims for the last five years. An unacceptable liability history is defined as: Within the five-year period immediately preceding the date of application, one or more legal actions resulted in: (1) at least one judgment; (2) one settlement in an amount of $50,000 or more; or (3) two or more settlements in an aggregate amount of $50,000 or more.
- The individual or entity does not owe any outstanding payments, fees, or documentation to any of the federal or state oversight authorities listed below, including, but not limited to, outstanding tax or payroll liabilities:
    - U.S. HHS or any of its divisions
    - NCDHHS or any of its divisions
    - NC Secretary of State (if organized as a corporation, partnership, or limited liability company)
    - U.S. Internal Revenue Service (IRS)
- No negative or questionable findings are identified for the individual or entity in any of the following databases/oversight authorities:
    - U.S. HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
    - U.S. System for Award Management (SAM) consolidated excluded parties list
    - NCDHHS Program Integrity Exclusion List
    - NC 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
    - NC Medicaid Program Integrity Database/State Exclusion List
    - National Accrediting Boards (e.g., CARF, Joint Commission on Accreditation of Hospitals)
    - Boards of licensure or certification for the applicable scope of practice
- The individual or entity is not currently subject to any of the following sanctions or administrative actions issued by Vaya or state or local regulatory agencies or has not been subject to any such sanctions or administrative actions within the 12 months prior to the application or 36 months for a renewal decision:

- Vaya or other LME/MCO: Contract termination or suspension, suspension of referrals, unresolved POC, outstanding overpayment, prepayment review, payment suspension
- NC Medicaid: Contract termination or suspension, payment suspension, prepayment review, outstanding final overpayment
- NC Division of MHDDSUS: Revocation of authority to receive public funds, unresolved POC
- NC DHSR: Unresolved type A or B penalty under Article 3, active suspension of admissions, active summary suspension, active notice of revocation, revocation in effect
- NC 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 Division of MHDDSUS 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 final upon notification to the provider, unless the provider timely requested an appeal review, in which case Vaya considers the action final upon issuance of a decision by an appeal review panel. Vaya is not required to enroll an applicant in the Vaya network or renew a network contract if the individual or entity has an LME/MCO sanction pending in any administrative or judicial form, including, but not limited to, OAH.

Vaya considers an action of NCDHHS or its divisions to be final upon notification to the provider, unless the provider timely requested an appeal review or administrative hearing, in which case Vaya considers the action final upon issuance of a decision by the NCDHHS Hearing Office or OAH, as applicable. Vaya is not required to enroll an applicant in our network or renew a network contract if the individual or entity has an NCDHHS 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/recipients.

PROHIBITED AFFILIATIONS

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

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person who is an employee of Vaya.

A "relationship" is described as follows:

1. A director, officer, or partner of Vaya;
2. A person with beneficial ownership of 5% or more of Vaya's equity; and

3. A person with an employment, consulting, or other arrangement with Vaya for the provision of items and services that are significant and material to Vaya's obligations under its contract with the State.

In addition, Vaya is prohibited from employing or contracting with providers excluded from participation in federal health care programs, including, but not limited to, those excluded under Section 1128 or Section 1128A of the Social Security Act. This includes Medicare and Medicaid. Vaya cannot knowingly submit encounter claims for services provided by excluded individuals and cannot receive Medicaid funds for such claims. If we discover that an individual billing Vaya for claims is on a prohibited affiliation list, we will immediately issue a suspension of the practitioner or provider's credentials and seek to recover any payments made during a period of prohibited exclusion, suspension, or debarment.

CREDENTIALING VERIFICATION REVIEW

The CVO continuously monitors the exclusion status of all providers to ensure Vaya does not pay federal funds to excluded persons or entities. Exclusion status is monitored through the following lists:

- State Exclusion List
- HHS-OIG List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- Social Security Administration Death Master File (SSADMF)
- To the extent applicable, National Plan and Provider Enumeration System (NPPES)
- Office of Foreign Assets Control (OFAC)

Vaya notifies NCDHHS within 30 calendar days of knowledge of any disciplinary actions imposed on any licensed physician, physician assistant, nurse practitioner, psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within our contracts with NCDHHS.

Vaya also checks, at least every month, the exclusion status of individuals with an ownership or controlling interest in Vaya (as applicable), agents, managing employees of Vaya, delegated entities, and subcontractors against the exclusion lists to ensure we do not pay federal funds to excluded persons or entities.

Vaya will take appropriate action upon identification that a person, agent, managing employee, network provider, delegated entities, or subcontractor appears on one or more of the exclusion lists, which may include termination of the relationship with and end of payments owed to the excluded individual.

CONTRACTING

Vaya makes network contracting decisions for providers of Medicaid physical health and pharmacy services based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates. During the Provider Credentialing Transition Period (no less frequently than every five years), as a provider is re-credentialed through the Provider Enrollment Process, Vaya evaluates a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on a daily Provider Enrollment File. After the Provider Credentialing Transition Period, Vaya will evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. Vaya applies the NCDHHS applicable Objective Quality Standards for participation as a State-funded services provider to contracted providers every three years, unless otherwise notified by NCDHHS.

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). You may not assign any of your rights, interest, or title in your written agreement with Vaya without notifying Vaya in advance of the intent to transfer and without securing Vaya's written consent for the assignment of the written agreement. Failure to provide advance notice to and receive prior written consent by Vaya may result in termination of your contract.

If Vaya approves the assignment of a network provider's written agreement to an assignee or accepts a successor owner for the provider's assets or business operations, the assignee/successor owner is required to accept liability for any and all overpayments or other debts owed to Vaya by the assignor at the time of the assignment or closing, as well as liability for any overpayments identified by Vaya in the future relating to dates of service prior to the assignment.

Provider contracts are on the state fiscal year cycle, from July 1 to June 30 of each year, with some providers offered an automatic renewal for one year. We use a unified contract template to ensure consistency across our network. The template does not include an attachment with a specific list of approved sites, services, and codes, eliminating the need for a contract amendment every time a change is made. Instead, providers must verify in the Provider Portal that its contract profile includes an accurate list of the sites, services, and codes it is enrolled to deliver and that this list aligns with its NCTracks profile. Upon request, Vaya can generate a report that lists all sites, services, and codes associated with your contract.

Please note that a cover sheet and Contact Maintenance Log is included at the front of your contract packet. Completing this log annually helps us improve the accuracy of contact information on file. **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 and administratively efficient, and it and automatically provides you with a scanned copy of your executed contract following execution. It lowers administrative costs, reduces contracting process timeframes, improves the tracking of executed contracts, and helps ensure contracts are executed prior to their effective date.

This manual is incorporated into your contract with Vaya as a binding requirement. It is important to review your contract for accuracy and read it carefully before executing. If you have questions about operational or substantive requirements, email provider.info@vayahealth.com. Suggested language for future agreements and questions about insurance requirements, legal terminology, or the DocuSign® contract process should be sent to contracts@vayahealth.com.

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

OUT-OF-NETWORK AGREEMENTS

If Vaya determines our network cannot meet the need for geographically accessible, appropriate, and/or timely services for a specific member, we may select an out-of-network provider to meet the need. The first step in this

process is to complete the Out-of-Network (OON) Agreement Request via DocuSign®. The request form is available on the Provider Enrollment page of Vaya's Provider Central website.

If approved, the agreement will proceed to final processing and execution. Completing the abbreviated verification process described in this section does not mean the provider is a member of Vaya's network. However, providers who serve multiple members under an OON agreement or who executed more than two OON agreements in a fiscal year may be invited to apply for network membership.

Access to Care

Providing timely access to medically necessary services is a key network function. It is your responsibility to ensure members/recipients 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 individuals for specialty care or to other contracted providers in response to a member/recipient request or change in level of care needed. Vaya's Eligibility and Enrollment Team and Member and Recipient 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. Members and recipients can access services through our Member and Recipient Service Line or Behavioral Health Crisis Line, or by contacting a network provider – there is no wrong door to access treatment. All network providers are required to complete eligibility determinations and request enrollment of an eligible individual into a Vaya health plan. Vaya's walk-in centers offer same-day access for behavioral health, I/DD, and TBI triage and/or assessment in each county in our region.

Network providers may conduct screening, triage, and referral following the process and criteria outlined below or may link individuals requesting services to Vaya's Member and Recipient Service Line at 1-800-962-9003. **In either case, all behavioral health, I/DD, and TBI network providers are required to meet the applicable Division of MHDDSUS 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 questions about eligible requirements, contact the Enrollment and Eligibility (E&E) Team at 1-800-893-6246, ext. 2355, or EandE@vayahealth.com. In general, to be eligible for Medicaid, the person 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 DSS where the individual resides.

NOTE: Individuals 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 Tailored Plan and remain under NC Medicaid Direct. 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)
- ACH Residents (SAD, SAA)
- Foster Care Children

Tailored Plan Eligibility Criteria

- Enrolled in the Innovations or TBI waivers or on the waitlists
- Enrolled in the Transition to Community Living (TCL) program
- Have used a Medicaid service that will only be available through a Tailored Plan
- Have used a behavioral health, I/DD, or TBI service funded with State, local, federal, or other non-Medicaid funds
- Are children with complex needs, as defined in the 2016 settlement agreement
- Have a qualifying I/DD diagnosis code
- Have a qualifying SMI, SED, or SUD diagnosis code and used a Medicaid-covered enhanced behavioral health service during the lookback period
- Have been admitted to a State Psychiatric Hospital or Alcohol and Drug Abuse Treatment Center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episodes in a State-owned facility
- Have had two or more visits to the ED for a psychiatric problem, two or more psychiatric hospitalizations or readmissions, or two or more episodes using behavioral health crisis services within 18 months

NC Medicaid Direct PIHP Eligibility Criteria

- Children/youth in foster care
- Children/youth who get adoption assistance
- Former foster care youth
- Children who get CAP/C services
- People who get CAP/DA services
- Federally recognized tribal members or others who qualify for services through Indian Health Service (HIS)
- People in the Program for All-Inclusive Care for the Elderly (PACE)
- People who are medically needy
- People who get Medicaid and Medicare
- People who may have a mental health disorder, substance use disorder, I/DD, or TBI
- People in the Health Insurance Premium Payment (HIPP) program
- People who get Family Planning Medicaid only

1915(c) Innovations Waiver Eligibility Criteria

- The individual is eligible for Medicaid based on the applicant's assets and income (not including family resources) whether they are a child or an adult.
- The individual's residence, for purposes of Medicaid eligibility, is in a county in Vaya's region.
- The individual is assigned a waiver "slot." (Note that NC Medicaid allocates Innovations Waiver to each LME/MCO. Vaya maintains a list of individuals wishing to be considered for waiver participation, known as the Registry of Unmet Needs.)
- The individual meets requirements for the ICF/IID level of care as approved by Vaya's UM Team.
- The individual lives in an ICF/IID or is at high risk for placement in an ICF/IID. (High risk for ICF/IID placement is defined as a reasonable indication the individual may need such services soon (one month or less) in the absence of HCBS.)
- 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 person. Waiver participants must use at least one waiver service per month to maintain eligibility.
- The individual and their family or guardian prefer waiver participation rather than institutional services.
- The waiver participant 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.

TBI Waiver Eligibility Criteria

Members with a TBI may be eligible for services and supports under North Carolina's TBI Waiver. Like the Innovations Waiver, the TBI Waiver provides a community-based alternative to institutional care for members with a TBI who meet medical necessity for an institutional level of care. Currently, NCDHHS has not expanded the TBI Waiver into any of the counties served by Vaya.

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 eligibility questions, contact the Enrollment and Eligibility (E&E) Team at 1-800-893-6246, ext. 2355, or at EandE@vayahealth.com.

State-Funded (Non-Medicaid) Services

Residents of the Vaya region without Medicaid or other insurance may be eligible for State-funded (non-Medicaid) behavioral health, I/DD, and/or TBI services. Some Vaya members with Medicaid may also qualify for State-funded services if an equivalent Medicaid service is not available. Eligibility for State-funded services is based on citizenship, income, and availability of other insurance. Some State-funded services, such as Respite for people with I/DD and the Adult Developmental Vocational Program (ADVP), are not based on income. Network providers must interview all individuals seeking State-funded services and document criteria as outlined below:

- Financial eligibility: Household income must be 300 percent or less of the current federal poverty guidelines, based on family size. The guidelines are issued the first month of each calendar year in the Federal Register by U.S. HHS and are a simplification of the U.S. Census Bureau poverty thresholds.
- Other third-party coverage: Other coverage must be exhausted or services not covered by the plan (proof of denial from insurer is required). 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, email the Vaya Enrollment & Eligibility (E&E) Team EandE@vayahealth.com or call 1-800-893-6246, ext. 2355, Monday-Friday, 8:30 a.m.-5 p.m. It is your responsibility to make a complete and thorough investigation of an individual's ability to pay prior to requesting to enroll the person in 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 people who may be eligible for Medicaid apply through the applicable county DSS.
- 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 any other payor is 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 individuals with third-party coverage may be enrolled with Vaya as the secondary payor.
- Determine if the individual is eligible for Vaya State-funded (non-Medicaid) services as outlined above.

Network providers are required to enroll eligible 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, they may be eligible for services through Vaya. If the individual was previously enrolled in a Vaya health plan, but claims for services have not been submitted for more than 90 days, you must complete a new enrollment. If the individual is not yet enrolled, then you must obtain and submit all data necessary to do so.

Required data elements include Medicaid ID number (if applicable), date of birth, and identification of any other third-party payor, including Medicare. It is your responsibility to ensure that enrollment data is accurate and current. Inaccurate or incomplete enrollment data may impact your ability to successfully submit SARs and claims for services.

Recipient enrollment must be performed electronically through the Vaya Provider Portal**. To verify an individual's enrollment, email EandE@vayahealth.com or call 1-800-893-6246, ext. 2355, 8:30 a.m.-5 p.m., Monday-Friday.** You must complete the eligibility determination and enrollment request prior to service provision, except for crisis services provided in a documented emergency. Claims submitted for services provided prior to date of enrollment will be denied.

MEMBER AND RECIPIENT SERVICES DEPARTMENT

Vaya operates a toll-free Member and Recipient Service Line at 1-800-962-9003 for telephonic screening, appointment referrals, and general questions from members, recipients, and the public. This number can also be used to report a compliment, grievance/complaint, or concern about Vaya or a network provider and is operational from 7 a.m. to 6 p.m., Monday through Saturday, including holidays. The department also operates a toll-free, 24/7/365 Behavioral Health Crisis Line at 1-800-849-6127. During times of heavy call volume, overflow calls may be automatically redirected to another Tailored Plan for backup.

Calls to both lines are answered by Member and Recipient Services (MRS) Representatives and MRS Clinicians:

- MRS Representatives are bachelor's-level or non-licensed QPs with at least two years of experience in the human services field. Their primary job responsibilities are to answer Member and Recipient Service Line calls, 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. MRS Representatives also provide information about community resources and inpatient facilities (when appropriate), ensure members/recipients discharged from inpatient facilities engage in the next level of care, and follow up on all appointments made through Vaya to confirm members/recipients attend scheduled appointments.
- MRS Clinicians are master's-level licensed professionals who manage emergency and crisis intervention calls, as well as regular MRS Representative duties. MRS Clinicians follow all requests for emergency services until contact is made with an MCM team, first responder, or other provider and are available to take over calls with individuals in distress.

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

- Crisis intervention, including referral to MCM
- Management and provision of referrals for urgent and emergent calls
- Referrals for diagnostic or Comprehensive Clinical Assessments
- Information about community (non-treatment) resources
- Vaya health plan enrollment
- Eligibility questions
- Documentation and submission of grievances/complaints
- General information about Vaya and publicly funded services available in our region

SCREENING, TRIAGE, AND REFERRAL PROCESS (BEHAVIORAL HEALTH, I/DD, AND TBI)

If the Individual Contacts Vaya's Member and Recipient Services Department:

If a caller does not request a clinical assessment or treatment services, the MRS Representative offers suggestions for obtaining natural supports and/or community services. If a caller requests a clinical assessment or treatment services, the MRS Representative gathers demographic information and determines whether risk indicators are present that necessitate MRS Clinician involvement.

If the call involves no risk indicators, the MRSR offers a choice of available network providers and links the caller to the selected provider for an intake appointment. When risk indicators are identified, the MRS Representative involves an MRS Clinician to determine the most clinically appropriate referral and clinical urgency for the appointment: emergent, urgent, or routine.

If the Individual Contacts a Network Provider:

If a caller does not request a clinical assessment or treatment services, you must offer suggestions for obtaining natural supports and/or community services. If a caller requests a clinical assessment or treatment services, you must gather demographic information and determine whether risk indicators are present that necessitate involvement of an appropriately licensed practitioner. If the call involves no risk indicators, you must schedule an intake appointment. When risk indicators are identified, you must ensure involvement of an appropriately licensed practitioner to determine the most clinically appropriate referral and the clinical urgency for the appointment: 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 (e.g., itching, bugs crawling)
- Confusion about date, time, location, current events, or recent history
- Report of hallucinations or hearing voices
- Signs of caller distress, including crying, yelling, or anger
- Report of feeling anxiety, panic, hopelessness, or fear
- Lethargic, unresponsive, or unable to comprehend questions
- Bizarre or unusual responses
- Significant inconsistencies in history as related by the individual and family
- Report of recent significant loss (e.g., death of loved one)

SCREENING, TRIAGE, AND REFERRAL CRITERIA

Emergent Service Requests

If the individual 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 on the individual exhibiting one or more of the following indicators:

- The individual has a current significant risk related to safety or supervision, as evidenced by:
    - Risk of harm without supervision, such as walking into traffic or wandering
    - Current harm without supervision
    - Impaired reality testing, such as delusions or hallucinations
    - Dangerous disruptive or bizarre behavior
- The individual 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 individual has severe incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health, I/DD, or TBI issues, such as:
    - Actively psychotic with impaired self-care functions (i.e., unable to care for the self on a daily basis regarding food, hygiene, toileting, etc.)
    - Bizarre thought processes
    - Recent physical, cognitive, or behavioral incapacitation related to behavioral health, I/DD, or TBI issues
- The individual 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 (e.g., 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 (addition).

Emergent services may be provided by an MCM team or a FBC provider. Individuals experiencing immediate life-threatening circumstances must be referred to the nearest hospital ED, or 911 may be called for emergency transportation to an ED.

Urgent Service Requests

If the individual 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 determination means the person presents with moderate risk of incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health, I/DD, or TBI issues and is made based on one or more of the following indicators:

- The individual 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 individual 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 individual has mild to moderate incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health, I/DD, or TBI issues, such as recent history of hallucinations, delusions, or bizarre thoughts, but none currently
- The individual is at mild risk for substance use withdrawal symptoms that could escalate if not addressed within 48 hours, as evidenced by:
    - Anxiety/depression, agitation, or insomnia
    - History of severe withdrawal but no recent/current substance use

Urgent services may be provided through an outpatient clinic or office, walk-in center, or an MCM team.

Routine Service Requests

Requests that do not establish an emergent or urgent need for services are classified as routine. This level of clinical urgency means the individual presents with mild risk or incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health, I/DD, or TBI issues. This determination is made based on one or more of the following indicators:

- The individual has mild to no risk related to safety or supervision, as evidenced by ability to care for self on a daily basis.
- The individual presents no risk of harm to self or others, as evidenced by denying any thoughts or plan to harm to self or others.
- The individual has mild to moderate incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health, I/DD, or TBI issues (e.g., mental health symptoms cause distress but are not currently incapacitating).
- The individual shows no indicators of significant risk for substance use withdrawal symptoms as evidenced by:
    - Mild agitation, anxiety, or depression
    - Reported minimal recent use or no substance use within the past several days
    - No history of significant withdrawal
    - Demonstrated motivation for treatment by agreeing to attend 12-step support during the period prior to assessment

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

DIVISION OF MHDDSUS ACCESS TO CARE TIMEFRAMES

If you accept a referral from Vaya's Member and Recipient Services Department, you are required to meet the applicable Division of MHDDSUS access to care timeframe based on the classifications in the table below.

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

Failure to meet these timeframes may result in referral for investigation and administrative action or sanction, up to and including termination of your contract with Vaya. Network providers should offer hours of operation that are not less than the hours of operation offered to individuals with commercial or other insurance. Providers are encouraged to offer evening and weekend hours.

PRIMARY CARE PROVIDER ACCESS TO CARE STANDARDS

The following timeframes are required when a Medicaid member seeks an appointment with their PCP:

- Urgent (not life threatening but needs care within 24 hours):
  - Pediatrics – see within 48 hours
  - Adults – see within 48 hours
- Symptomatic non-urgent:
  - Pediatrics – see within 30 calendar days
  - Adults – see within 30 calendar days
- Follow-up of urgent care:
  - Pediatrics – see within seven days
  - Adults – see within seven calendar days
- Chronic care follow-up:
  - Pediatrics – see within 14 days
  - Adults – see within 14 calendar days
- Complete physical/health maintenance:
  - Pediatrics – see within 60 calendar days
  - Adults – see within 60 calendar days
- Time in waiting room:
  - Scheduled – after 30 minutes, the member must be given an update on waiting time with an option of waiting or rescheduling. The maximum wait time is 60 minutes.

    - Work-ins/walk-ins (called the day prior to coming) – after 45 minutes, the member must be given an update on waiting time with an option of waiting or rescheduling. The maximum wait time is 90 minutes.
- After-hours coverage:
    - Urgent – 20 minutes
    - Other – 60 minutes
- All network PCPs are required to have a recorded telephone message instructing the member to go to the ED for a life-threatening event or refer them to the physician on-call, the answering service, or the nurse triage service.
- All network PCPs are required to make interpreter services available either in the practice, with a contracted interpreter phone line, or through hospital interpreter services.
- All network PCPs are required to post hours during which appropriate personnel are available to members:
    - Daytime – seven hours per day/five days per week
    - Nighttime – 24 hours/day coverage
    - Weekend – 24 hours/day coverage

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 their treatment or recovery. Vaya's Member and Recipient Services Department can help by providing current information on network providers accepting referrals. Please be as clear as possible in requests for information or services. For information on how to work with Vaya's Member and Recipient Services Department to schedule appointments through Vaya's 10to8 software scheduler, email member.services@vayahealth.com.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

If a Tailored Plan Medicaid member needs transportation for non-emergency health care services covered by Medicaid, Vaya can arrange and pay for transportation to and from appointments at a provider's office, a hospital, or another medical office. We can also arrange for member transportation to the pharmacy to pick up prescription medications. This service is called non-emergency medical transportation (NEMT), and it is free to all eligible Medicaid members. Vaya will also pay for transportation for an attendant to go with the member to the appointment, if needed. If an adult is a parent or guardian of a child (age 18 or younger) who is a Vaya Tailored Plan member, we will also pay for the adult to accompany them.

Vaya contracts with a company called Modivcare to manage NEMT services for Tailored Plan members. To request NEMT for a routine appointment, members must call Modivcare Member Services at 1-888-621-2084 (7 a.m. – 6 p.m., Monday – Saturday) or Vaya Member and Recipient Services at 1-800-962-9003 at least two business days before the appointment. Members may also request NEMT via the Vaya Member and Recipient Portal. Vaya can also help members get transportation to and from an urgent appointment that they did not know about in advance.

The member must arrive at the provider's location in time for the scheduled appointment, but not more than one hour before the appointment. The member must stay until their treatment or other service is finished and is picked up within an hour after the appointment ends. NEMT includes personal vehicles, taxis, vans, mini-busses,

mountain area transports and public transportation. Vaya will pay for the least expensive transportation method that meets the member's needs.

In the past, local DSS offices managed all NEMT services. The amount, duration, and scope of available NEMT services has not changed under NC Medicaid Managed Care. However, there are rules the member must follow, including limits on transportation, expected behavior and "no-shows". If we deny a member transportation services, the member has the right to appeal our decision.s

As a Vaya network provider, you must help the members you serve access NEMT services. Please note that Vaya does not manage NEMT for the following populations:

- NC Medicaid Direct PIHP members: County DSS agencies continue to arrange for NEMT services
- Members in a nursing home (the facility is responsible for providing transportation to their patients)
- Members transferring between facilities and/or hospitals
- Recipients of State-funded services (NEMT is a Medicaid service only; county-provided public and human services transportation may exist and depends on available space, charges a fee, and is largely unavailable in the evening or on weekends)

Modivcare Transportation Broker Services

Modivcare will help you facilitate access to NEMT services for the members you serve. Modivcare offers a comprehensive network using transportation providers who are familiar with the Tailored Plan and are equipped with specific situational behavioral health training to manage member needs during transportation. Modivcare evaluates prospective transportation providers, including a complete evaluation of appropriate licensing, adequate insurance coverage, civil and criminal records check, and background checks on personnel providing services. Modivcare continuously assesses its network coverage to determine areas where adding providers will enhance trip timeliness and highlight cost-containment opportunities.

The ride request and scheduling process begin when a member, care manager, or Modivcare's Medical Transportation Coordinator (MTC) determines that transportation services are needed for a member. Members can contact Modivcare directly and can also talk to a Vaya MRS Representative to be warm transferred to Modivcare. Members may also contact their care manager for scheduling assistance. Modivcare operates from 7 am to 7 p.m., Monday-Friday, maintains phone line operations Monday-Friday; and has an after-hours recording that provides the option to leave a message to be returned the next business day.

Modivcare verifies each member's Medicaid eligibility against a daily eligibility file received from Vaya. This file is loaded into the trip intake platform and automatically verifies members at intake, verifies the trip is for a covered service or benefit, and verifies if the member is within the established limitations. If Modivcare cannot verify this information, it refers the member's trip to Vaya for a decision. Vaya sends the member the appropriate denial notice or provides prior authorization so Modivcare can schedule the trip.

Modivcare prioritizes urgent requests and immediately reaches out to transportation providers based on service area and capacity to ensure trips are scheduled within required timeframes, making best efforts to arrange transportation. Modivcare also has a team that works directly with medical providers and facilities to manage transportation for members requiring recurring trips or acute care needs such as dialysis, chemotherapy, and behavioral health treatment.

Modivcare offers several ways to request NEMT, including dedicated phone lines, email access, and direct online access via web-based dashboards for real-time scheduling:

- **Phone:** The member or Vaya calls the Modivcare dedicated, toll-free number and provides the necessary information.
- **Fax:** Vaya or the health care provider faxes the necessary ride request information to Modivcare.
- **Email:** Vaya or the health care provider emails the necessary ride request information to Modivcare.

Modivcare's website (modivcare.com) provides the following information:

- Customer contact center and after-hours assistance information
- Description of transportation services available and how to access them, including member eligibility requirements and how to request trips
- Complaint submission processes, including how to file a complaint (grievance) and any appeal rights available
- Member responsibilities
- Member conduct policy
- Frequently asked questions (FAQs)

Member Access to NEMT Services

Vaya's Tailored Plan Member Welcome Packets include information on how to access NEMT services. As a part of our NEMT education efforts and in keeping with federal and state Medicaid policy, Vaya notifies all Tailored Plan members that:

- Members are not required to make transportation requests more than two days in advance;
- Members are not required to make transportation requests in person; and
- Urgent transportation services are exempt from any advance-notice requirement.

Likewise, members are informed there is no cost for NEMT services. Vaya also explains how to request or cancel a trip, any limitations on transportation, who may accompany the member without cost, expected member conduct, and procedures for no-shows. Any member under age 18 does not have to ride alone. Vaya's NEMT policy provides that members:

- Can arrive at the provider in time for the scheduled appointment but no sooner than one hour before the appointment;
- Do not have to wait more than one hour after the conclusion of the treatment for transportation home;
- Are not to be picked up prior to the completion of treatment; and
- Can request an appeal if the request for transportation assistance is denied.

No-reject Requirements

Vaya requires that network providers have a "no-reject" policy for referrals made by Vaya. This means you cannot reject referrals unless you are at capacity or do not provide the most appropriate service for the individual. If you reject a referral on any other basis, you must notify us of the reason for your decision.

Notification of Changes in Address

Providers are responsible for making address changes related to claims, including site(s) of service and billing office location(s), by updating this information in NCTracks.

Insurance Requirements

Network providers must maintain and provide proof of insurance upon request as required under the terms and conditions of their contract.

Licensure Requirements

Network providers and their employees must maintain and provide proof of licensure as required under the terms and conditions of their contract and as outlined in the NCDHHS Credentialing and Re-credentialing Policy.

7

SECTION 7
Telehealth, Virtual Patient Communications, and Remote Patient Monitoring

Vaya supports broad access to health care services from eligible providers who are not at the member's/ recipient's location using electronic communications systems, including real-time interactive audio-visual communication, virtual communication, and remote patient monitoring. This alternative service delivery model may only be used when clinically appropriate and in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. Services provided via telehealth, virtual patient communications, and remote patient monitoring must be provided in an amount, duration, and scope no less than the amount, duration, and scope for the same services when provided in person.

Services may be provided via telehealth when equivalent in-person (face-to-face) services are not available or if the individual prefers this modality. Telehealth services are intended to overcome geographic, transportation, or other barriers to connect members/recipients and providers. NC Medicaid's Telemedicine and Telepsychiatry Clinical Coverage Policy (CCP 1H) details the requirements for provision of telehealth services and is available on the NCDHHS website.

Telehealth is a covered plan benefit subject to limitations and administrative guidelines. Telehealth is defined as the use of two-way real-time interactive audio and video to provide and support health care services when Beneficiaries and Providers are in different physical locations. Telehealth facilitates the assessment, care management, consultation, diagnosis, education, self- management, and treatment of a person's health care between a provider or prescriber located at a distant site and a member/recipient located at an originating site. Telehealth as used in this manual is inclusive of both telemedicine and telepsychiatry. Telehealth services provide the member/recipient with enhanced health care services, the opportunity to improve health outcomes, and information when meeting face-to-face is not possible. Providers are not permitted to require members/ recipients to participate in telehealth if they prefer to receive services in-person.

Virtual patient communication is defined as the use of technologies other than video to enable remote evaluation and consultation support between a Provider/Prescriber and a Beneficiary or a Provider/Prescriber and another Provider/Prescriber. Covered virtual patient communication services include telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

Remote patient monitoring is defined as the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a Provider/Prescriber in a different location. This monitoring method enables Providers/Prescribers to collect and analyze information such as cardiac monitoring or vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. The two types of permitted remote patient monitoring are:

- Self-measured and reported monitoring: when a patient uses a digital device to measure and record their own vital signs, then transmits the data to a Provider/Prescriber for evaluation.
- Remote physiologic monitoring: when a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a Provider/Prescriber.

Vaya will reimburse providers for services covered in their contract with us that are provided through telehealth, when appropriate, and in an amount, duration, and scope to the same extent the services would be covered if provided through a face-to-face (in-person) encounter with a practitioner. Telehealth is reimbursed when service requirements are met and:

- The practitioner providing the telemedicine service is licensed within their scope of practice to perform the service.
- Telehealth services are provided using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between a member/recipient and a practitioner.
- A GT modifier is included on claims to indicate the delivery method was telemedicine.

Medical professionals are encouraged to follow telehealth guidance provided by the North Carolina Medical Board. Telehealth can be a useful tool for increasing access to care, expanding specialty expertise, and reducing patient cost. However, the medical board cautions that telehealth providers will be held to the standards of care applicable to their area of specialty, with the same requirements for quality and outcomes as occurs with in-person care. For telemedicine guidance, refer to the NC Medicaid Provider Telehealth Education webpage.

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SECTION 8
Network Adequacy and Access Standards

Vaya's policy is to develop and maintain a sufficient network of high-quality service providers that meets member, recipient, and community needs within available resources. **In accordance with N.C. Gen. Stat. § 108D-22, Vaya operates an open network for physical health and pharmacy services and will not exclude any of these providers from the network except when a provider refuses to accept network rates.** To meet NCDHHS availability, accessibility, and quality goals and requirements, Vaya will negotiate with any willing provider, except for the following services, which are not available through Standard Plans and for which we will maintain a closed network:

- Assertive Community Treatment (ACT)
- Child and Adolescent Day Treatment
- Community Support Team (CST)
- Intensive In-home services
- Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) services
- Multisystemic Therapy
- NC Innovations Waiver services
- Psychiatric Residential Treatment Facilities (PRTFs)
- Psychosocial Rehabilitation
- Residential Treatment Facility services
- State-funded (non-Medicaid) services
- Substance Abuse Medically Monitored Residential Treatment
- Substance Abuse Non-medical Community Residential Treatment
- Transitions to Community Living (TCL) program services

In accordance with 42 CFR 438.206, Vaya is not required to review the qualifications and credentials of providers that wish to enroll in the closed network if Vaya has enough providers with the same or similar qualifications and credentials to provide adequate access to all services. 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 outcomes and performance measures to ensure the service system meets the health care needs of the individuals we serve.

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

Network Access Plan

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

Primary Care Providers

A primary care provider (PCP) is the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the member to provide and coordinate all the member's health care needs and to initiate and monitor referrals for specialized services, when required.

PCPs in Vaya's network may set limits on panel size. PCPs are responsible for communicating panel size limits and capacity for accepting referrals to our Provider Network Operations (PNO) Department. PCPs must inform PNO about changes in their panel capacity. If a PCP reaches full panel capacity, the PCP submits this information to PCPenrollment@vayahealth.com for processing by Vaya's Provider Network Enrollment Team.

Vaya's methodology for assigning members to a PCP includes the following components, in this order, to the extent that such information is available:

- Prior PCP assignment
- Member's claims history
- Family member's PCP assignment, as appropriate
- Family member's claims history, as appropriate
- Geographic proximity
- Special medical needs
- Language/cultural preference and
- AMH+ status or AMH status (Tiers 2 and 3)

Vaya informs existing members of a new PCP assignment through U.S. mail within seven business days of the change. This notification includes a replacement Medicaid ID card, provided free of charge, with the new PCP name, physical address, and phone number. This information is also available through our Member and Recipient Portal.

Members can change their PCP without cause twice per year. Members have 30 days from receipt of their annual notification of PCP assignment to change their PCP without cause (first instance) and may change their PCP without cause up to one time per year thereafter (second instance). Members may change their PCP with cause at any time. A PCP's failure to furnish accessible and appropriate medical care, services, or supplies to which the member is entitled constitutes appropriate cause. Examples include, but are not limited to, the instances below:

- The PCP fails to do any of the following:

  - Provide primary care services
  - Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary
  - Arrange for consultation appointments
  - Coordinate and interpret any consultation findings with an emphasis on continuity of medical care
  - Arrange for services with qualified licensed or certified providers
  - Coordinate the member's overall medical care, such as periodic immunizations and diagnosis and treatment of any illness or injury
- The member disagrees with a treatment plan
- The member and provider are not able to communicate due to a language barrier or other impediment to communication
- The provider is not able to reasonably accommodate the member's special needs
- There is a change in the provider's practice, including, but not limited to, the following:
  - The provider moves to a location that is not convenient for the member
  - There is a significant change in the hours the provider is available, and the member cannot reasonably make appointments during the new hours
- The provider no longer has hospital access
- The member and the provider agree a change would be in the best interest of the member
- The provider leaves Vaya's network

Existing members who want to change their PCP without cause must contact the Member and Recipient Service Line or complete the Primary Care Provider Change Request Form. Existing members who want to change their PCP with cause must contact the Member and Recipient Service Line. When the assigned PCP changes, the newly assigned PCP is eligible for value-based payments on the first day of the following month.

A PCP may remove a member from their panel by calling Vaya's Member and Recipient Service Line to trigger the re-assignment process. The PCP must also send a letter to the member informing them of:

- The reason for removal from their panel (e.g., repeated history of no shows or tardiness, stolen property, ethical concerns, hostility/threats towards PCP or staff within the PCP office);
- Explanation that the PCP will provide emergency treatment only to the member for a minimum of a 30-day period or in accordance with state law; and
- Referral to Vaya's Member and Recipient Service Line to request re-assignment of a PCP.

The PCP must retain a copy of this letter in their records to ensure adequate notice was given to the member (e.g., greater than or equal to 30 days). Vaya may monitor for trends in panel removal by a PCP and report any concerning trends (e.g., sex, race, ethnicity, sexual orientation) for consideration of monitoring or investigation to the Provider Quality Assurance Team. Vaya allows members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such members direct access to a specialist as appropriate to the member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4).

Network Adequacy and Accessibility Standards

To make certain that members and recipients have timely access to covered services, Vaya ensures its network meets the time and distance standards established by CMS, NC Medicaid, and the Division of MHDDSUS. Vaya will

comply with any new standards adopted by NCDHHS, either through an amendment or as directed through formal notice.

Vaya's provider network for physical health services consists of hospitals, physicians, advanced practice nurses, behavioral health providers, I/DD and TBI providers, emergent and non-emergent transportation services, safety net hospitals, and other provider types necessary to support capacity to meet the member needs. Specialty care providers include the following service types:

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Endocrinology
- ENT/otolaryngology
- Gastroenterology
- General surgery
- Gynecology
- Infectious disease
- Hematology
- Nephrology
- Neurology
- Oncology
- Ophthalmology
- Optometry
- Orthopedic surgery
- Pain management (Board-certified)
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- Urology

For purposes of network adequacy, for physical health providers/services, except as otherwise noted, adult services are those provided to members/recipients age 21 or older, and pediatric (child) services are those provided to members/recipients under age 21. For purposes of network adequacy standards for behavioral health, I/DD, and TBI providers, except as otherwise noted, adult services are those provided to members/recipients age 18 or older, and pediatric/adolescent (child) services are those provided to members/recipients under age 18. Vaya measures network adequacy through multiple mechanisms throughout the year, including geo-access mapping (at least annually), monthly reviews of service availability, our annual Community Needs Assessment Survey, and committee review of our service gaps reporting form submissions.

Most services will be available within 30-45 miles or 30-45 minutes driving time. There is at least one behavioral health walk-in center location in every county. However, because of insufficient demand and economy of scale factors, some specialty providers may be located outside this radius, or there may only be one provider available to deliver the needed service. The annual Network Adequacy and Accessibility Analysis report evaluates the ability of network providers to meet member/recipient needs and measures geographic access to service locations.

Time and distance standards vary depending on whether a county is classified as urban or rural. Counties with an average population density of 250 or more people per square mile are classified as urban; counties with an average population density of less than 250 people per square mile are considered rural.

Time and Distance Standards

Service Type	Urban Standard	Rural Standard
Primary Care	Greater than or equal to two providers within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two providers within 30 minutes or 30 miles for at least 95% of members

Time and Distance Standards		
Specialty Care	Greater than or equal to two providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	Greater than or equal to two providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Hospitals	Greater than or equal to one hospital within 30 minutes or 15 miles for at least 95% of members	Greater than or equal to one hospital within 30 minutes or 30 miles for at least 95% of members
Pharmacies	Greater than or equal to two pharmacies within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two pharmacies within 30 minutes or 30 miles for at least 95% of members
OB-GYN	Greater than or equal to two providers within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two providers within 30 minutes or 30 miles for at least 95% of members
Occupational, Physical, or Speech Therapists	Greater than or equal to two providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
Outpatient Behavioral Health Services	Greater than or equal to two providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of members *Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*	Greater than or equal to two providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members *Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*
Location-Based Services	Greater than or equal to two providers of each service within 30 minutes or 30 miles of residence for at least 95% of members *For NC Medicaid Direct* members, this includes Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment *Child and Adolescent Day Treatment Services: Not subject to standard*	Greater than or equal to two providers of each service within 45 minutes or 45 miles of residence for at least 95% of members *For NC Medicaid Direct* members, this includes Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment *Child and Adolescent Day Treatment Services: Not subject to standard*

Time and Distance Standards		

Crisis Services	• Professional treatment services in an FBC program: the greater of:
	  ○ Two or more facilities within the Vaya region OR
	  ○ One facility within the Vaya region per 450,000 total regional population (as estimated by combining NC Office of State Budget and Management [OSBM] county estimates)
	• FBC services for children and adolescents: greater than or equal to one provider within the Vaya region
	• Non-Hospital Medical Detoxification: greater than or equal to two providers within the Vaya region
	• Ambulatory Detoxification, Ambulatory Withdrawal Management with Extended On-site Monitoring, Clinically Managed Residential Withdrawal: greater than or equal to one provider of each service within the Vaya region
	• All other crisis services: greater than or equal to one provider of each crisis service within the Vaya region
	• *Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adult): Not subject to standard*	

Inpatient Behavioral Health Services	Greater than or equal to one provider of each inpatient behavioral health service within the Vaya region	
Partial Hospitalization (Behavioral Health)	Greater than or equal to one provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	Greater than or equal to one provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	Greater than or equal to two providers of clinically managed low-intensity residential treatment services within the Vaya region	
All State Plan LTSS (except Nursing Facilities and 1915(i) Services)	Vaya is required to have at least two LTSS provider types (home care providers and home health providers, including home health services, private duty nursing services, personal care services, and hospice services) that are identified by distinct NPI, accepting new patients and available to deliver each State Plan LTSS in every county.	Vaya is required to have at least two providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
Nursing Facilities	Greater than or equal to one nursing facility accepting new patients in every county	Greater than or equal to one nursing facility accepting new patients in every county

Time and Distance Standards	
Community/Mobile Services	Greater than or equal to two providers of community/mobile services within the Vaya region Each county in the Vaya region must have access to greater than or equal to one provider that is accepting new patients

Residential Treatment Services	• Residential Treatment Facility Services: greater than or equal to one licensed provider within the Vaya region
	• Substance Abuse Medically Monitored Residential Treatment: greater than or equal to one licensed provider within the Vaya service region
	• Substance Abuse Non-Medical Community Residential Treatment:
	  ○ Adult: greater than or equal to one licensed provider within the Vaya service region
	  ○ Adolescent: contract with all designated Cross-Area Service Programs (CASPs) within the Vaya region
	  ○ Women and children: contract with all designated CASPs within the Vaya region
	• Substance Abuse Halfway House:
	  ○ Adult: greater than or equal to one male and one female program within the Vaya region
	  ○ Adolescent: greater than or equal to one program within the Vaya region
	• *PRTF and ICF/IID: Not subject to standard*

1915(i) HCBS	• Community Living and Support, Individual and Transitional Support, Respite, and Supported Employment (for I/DD and mental health/substance use disorder): greater than or equal to two providers of each 1915(i) service within the Vaya region
1915(c) HCBS Waiver Services: NC Innovations	• Community Living and Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: greater than or equal to two providers of each Innovations Waiver service within the Vaya region • Crisis Intervention and Stabilization Supports, Day Supports, Financial Support Services: greater than or equal to one provider of each Innovations Waiver service within the Vaya region • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Goods and Services, Natural Supports Education, Specialized Consultation Services, Vehicle Modifications: Not subject to standard*

SERVICE CATEGORIES FOR BEHAVIORAL HEALTH TIME AND DISTANCE STANDARDS	
Service Category	**Services that fall within the Category**
Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based Behavioral Health Treatment for Autism Spectrum Disorder (ASD)
Location-Based Services	• Psychosocial Rehabilitation • Substance Abuse Comprehensive Outpatient Treatment (adult) • Substance Abuse Intensive Outpatient Program (adults and children) • Opioid Treatment Program (OTP) (adult) • Child and Adolescent Day Treatment services
Crisis Services	• Adult FBC • Child FBC • Non-hospital Medical Detoxification (adult) • Ambulatory Withdrawal Management with Extended On-site Monitoring • Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adult) • Ambulatory detoxification • Clinically Managed Residential Withdrawal Management
Inpatient Behavioral Health Services	**Inpatient Hospital – Adult** • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds **Inpatient Hospital – Adolescent/Child** • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
Partial Hospitalization	Partial Hospitalization (adults and children)
Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	Clinically Managed Low-intensity Residential Treatment Services

SERVICE CATEGORIES FOR BEHAVIORAL HEALTH TIME AND DISTANCE STANDARDS	
Residential Treatment Services	• Residential Treatment Facility Services • Substance Abuse Non-medical Community Residential Treatment • Substance Abuse Medically Monitored Residential Treatment • PRTF • ICF/IID
Community/Mobile Services	• ACT • CST • Intensive In-home services • Multi-systemic Therapy services • Peer Supports • Diagnostic Assessment • Mobile Crisis Management (MCM) services
1915(i) HCBS	• Supported Employment • Individual and Transitional Support • Respite • Community Living and Support • Community Transition
1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention and Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation Services • Supported Employment • Supported Living • Vehicle Modifications

SECTION 9
Billing and Reimbursement

This section provides a high-level overview of the provider billing and reimbursement process. For more information about claims or reimbursement, contact us at 1-800-893-6246, ext. 2455, or at claims@vayahealth.com.

Billing Prerequisites

Network providers are responsible for ensuring that all billing prerequisites are met prior to claim submission:

- **Enrollment and member/recipient ID:** As explained in Section 6 of this manual, the individual must be eligible for and enrolled in a Vaya health plan for a claim to be processed. The member/recipient ID number identifies the individual receiving the service and is assigned by Vaya's Conduent HSP claims system. All claims submitted with incorrect member/ recipient ID numbers, or for members/recipients 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 3 of this Manual, Vaya must authorize certain services 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, and providers must have policies and procedures that recognize and accept Medicaid as the payor of last resort. All other available first- and third-party payments must be exhausted prior to billing Vaya. If the individual is eligible, State funds must be exhausted prior to billing Medicaid.
- **NPI and taxonomy:** All providers must have an NPI number to submit billing on the CMS 1500 and UB04 forms. Best practice for successful claims submission is to obtain a separate NPI number for each site from which services are billed. Accurate NPI numbers and taxonomy codes are required for claims to be accepted and processed. Failure to comply with these guidelines may result in denied claims and/or recoupment of previously paid claims.
- **NCTracks:** Network providers are responsible for ensuring provider names, billing addresses, site addresses, NPI numbers, and taxonomy information submitted to Vaya are verified, accurate, and exactly match the information in NCTracks, North Carolina's Medicaid Management Information System (MMIS). Failure to adhere to this requirement will result in claims denial or recoupment.
- **Documentation and service delivery requirements:** Network providers are responsible for ensuring services are delivered and documented in accordance with Controlling Authority outlined in your contract, including, but not limited to, NC Medicaid CCPs and the Division of MHDDSUS 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. Additional restrictions affect payment for services delivered to people admitted to facilities with more than 16 beds that are classified as Institutions for Mental Diseases

(IMDs). This may include some state facilities, private hospitals, ACHs, and FCHs. It is your responsibility to know whether an individual 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 under investigation for fraud or abuse or a claim under review for medical necessity. It is your responsibility to ensure claims 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 Vaya has accurate EFT, tax ID, and W-9 information on file prior to claims submission.

Authorization Specifics

- **Date of service (DOS):** Each authorization contains a unique number, start date, and end date. Only claims with dates of service within these specific timeframes will be paid. Dates and/or units outside these parameters will be denied.
- **Type or code:** Each authorization indicates the specific service or service code authorized. Each service is validated against the authorization to make sure the service billed matches the service authorized. Claims that fall outside of these parameters will be denied.
- **Units:** Each authorization indicates the maximum number of units of service authorized for the specified time period. Vaya checks to make sure the units claimed fall within the units authorized. Claims that exceed the limits will be denied. Network providers must establish internal procedures to monitor units of service against authorizations to avoid claims denials.
- **Exceptions:** Certain services do not require authorization at all or do not require prior authorization for an initial service period, referred to as the "pass-through" period. These services are limited in scope, and the pass-through limits are applied per member/recipient, not per provider. Section 3 of this manual details services that do not require authorization or have a pass-through limit. Once the pass-through limit is reached for an individual, all claims submitted without an authorization will be denied. Network providers must be constantly aware of this issue to avoid denied claims.

Claims Submission

METHOD

Network providers (or billing agents or clearinghouses) must submit all claims through the Vaya Provider Portal or through a HIPAA-compliant EDI file, unless your contract specifically states an alternative method. Vaya does not accept paper claims 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, to prevent a duplicate billing denial. Vaya will accept only HIPAA-compliant transactions as required by law:

- Basic benefit services, Outpatient Therapy, enhanced services, Innovations Waiver services, and State-funded residential and other daily and periodic services must be submitted using the American National Standards Institute ANSI 837P (professional) format or the electronic CMS 1500 form if billing through the Vaya 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 Provider Portal.

- Vaya accepts paper claims only from out-of-network hospitals or physician groups that submit claims for services delivered in an ED setting. These providers are required to submit an accurate CMS 1500 or UB04 billing form with the correct data elements.

TIMEFRAMES

All ED and inpatient facility claims must be submitted within 365 days of the date of discharge, unless otherwise specified in your contract. In general, all other claims must be submitted within 365 days of the date of service. **Claims in which Vaya is the secondary payor must be submitted within 180 days of the date you receive a denial from a first- or third-party payor.** In the case of retroactive Medicaid eligibility, the timely filing requirement of 365 days is measured from the date NCDHHS determines member eligibility. **Claims submitted outside of these timeframes will be denied.** Claims must be submitted no less than monthly. Vaya encourages network providers to produce routine billings on a weekly or bi-monthly schedule in conjunction with the checkwrite schedule available on our website.

837 FILE SUBMISSION

Network providers who wish to submit using an 837 file must complete training, successfully submit and receive test files, and execute a Trading Partner Agreement. Training and additional information is available on our Provider Central website. Detailed instructions for 837 file submission are provided in the HIPAA Transaction Professional (837P) and Institutional (837I) Transaction Companion Guides, which explain the entire testing and approval process. HIPAA-compliant ANSI transactions are standardized; however, each payor can exercise certain options and require use of specific processes. The purpose of the companion guide is to clarify those choices and requirements so that network providers can submit accurate HIPAA transactions. NC Medicaid uses data validation protocols for encounter data files to assess encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits, which are standardized expected levels of accuracy), and claims can be edited based on the results of the data validation protocols.

Vaya returns the following HIPAA transaction files to providers: 999 (an acknowledgment receipt), 824 (a line-by-line acceptance/rejection response), and 835 (an electronic version of the remittance advice).

RATES

Vaya reimburses all network providers at the lesser of the Vaya published rates for the service provided or your usual and customary charge for the service, unless otherwise stated in your contract or identified in the Provider Portal. In general, Vaya follows the NC Medicaid fee schedule for Medicaid services. Vaya announces rate changes at least 30 days in advance unless they result from a change imposed by the General Assembly, NC Medicaid, or the Division of MHDDSUS. You can submit claims for more than the published rates, but Vaya will pay only the published or contracted rate. 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 your billing systems. A provider who accepts an individual as a Medicaid patient agrees to accept Medicaid payment, plus any authorized deductible, co-insurance, co-payment, and third-party payment as payment in full for all Medicaid-covered services or supplies provided as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2).

Vaya will make payments for Tailored Care Management (TCM) according to the provider payment requirements described in Section 4 (Care Management) of this manual. Additionally, Vaya pays minimum medical home fees to all AMH practices and additional TCM fees to AMH+ practices. TCM fees differ based on a member's acuity level.

Vaya collaborates with AMH+ and CMA practices to design and support innovations in care delivery, data sharing, and payment models according to each AMH+/CMA's strategies, capabilities, and, most importantly, member needs and preferences.

SITES AND SERVICES

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

CODES AND UNITS

Providers are required to use standard codes for claims submission, which include the following:

- Current Procedure Terminology (CPT) codes and modifiers
- Healthcare Common Procedure Coding System (HCPCS) codes and modifiers. Note that the HCPCS includes specific requirements regarding unit billing. For example, when only one service is provided in a day, providers should not bill for services performed for less than eight minutes. For any single-timed CPT code in the same day measured in 15-minute units, providers should bill a single 15-minute unit for treatment greater than or equal to eight minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then two units should be billed.
- CMS Uniform Billing Revenue codes and modifiers (UB04 submission)
- Place of service codes
- ICD-10 Diagnosis Codes: ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. You must provide diagnosis codes from the ICD-10 Code Manual 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 (DSM-5 TR).

For more information about coding and ICD-10 implementation, please see our Provider Central website.

Coordination of Benefits (COB)

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. These 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 6 of this manual, network providers must conduct a comprehensive eligibility determination process whenever a member is enrolled. You must also regularly monitor and update eligibility information if the member's circumstances change.

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

If the member is eligible for State-funded services, you must exhaust State funds prior to billing Medicaid. Conduent HSP can validate third-party payors and deny or adjust the claim. Out-of-network hospitals and physician groups permitted to file paper claims with Vaya are 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 submitting a claim to Vaya, you must notify us and submit reimbursement within 30 days of receipt of the first- or third-party funds.

Once you accept referral of a Medicaid beneficiary from Vaya, you must accept Medicaid reimbursement as payment in full for the service (other than legitimate first- and third-party payments or applicable copays, as noted in Section 6 of this manual). You may not charge a Medicaid member for services delivered under your contract with Vaya if we deny authorization or reimbursement. If you collected funds from Medicaid members for any services delivered under your contract with Vaya, you must notify Vaya and immediately return all funds received from the member or responsible party.

Remittance Advice and Claims Inquiries

The RA is the standard method of informing providers exactly how each claim is adjudicated. They are available in the download option of the Provider Portal following each checkwrite and 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 RA known as the 835. The 835 electronically reports claims status and payment or denial information.

Please direct questions about claims status to your assigned Vaya claims specialist or Claims Department staff at 1-800-893-6246, ext. 2455, or claims@vayahealth.com. Section 11 of this manual outlines the process to appeal any claims denials.

Network providers are directly responsible for managing accounts receivable. Vaya does not make advance payments or payments outside the posted checkwrite schedule, except in documented situations in which a provider was not paid due to an error of Vaya or its vendors. We must comply with liens imposed by courts or government agencies such as the U.S. Internal Revenue Service (IRS) or NC Department of Revenue.

Vaya processes and pays claims in accordance with the NC Medicaid prompt pay timeframes outlined in Vaya's contract with NC Medicaid, Section 1902(a)(37)(A) of the Social Security Act, and 42 CFR § 447.45 as follows:

- Within 18 calendar days after Vaya receives a clean claim or invoice from a provider for a medical claim, Vaya shall either:
    - Approve payment of the claim/invoice;
    - Deny payment of the claim/invoice; or
    - Determine that additional information is required for making an approval or denial.

- Within 14 calendar days after Vaya receives a clean claim or invoice from a provider for a pharmacy claim, Vaya shall either:
    - Approve payment of the claim/invoice;
    - Deny payment of the claim/invoice; or
    - Determine that additional information is required for making an approval or denial.

Approved medical claims are paid within 30 calendar days of the approval date. The 30 days includes the first 18 days to determine if a claim can be paid or denied. Approved pharmacy claims are paid within 14 calendar days of the approval date. The 14 days includes the first 14 days to determine if a claim can be paid or denied.

If any approved claim is not paid to a provider, including, but not limited to, AMH+ practices and CMAs, within the required time period, interest will accrue to be paid to the provider at the annual rate of 18% of the claim amount beginning on the date following the day on which the payment should have been made. In addition to interest on late payments, Vaya will pay the provider a penalty equal to 1% of the claim for each calendar day following the date the claim should have been paid. Please note Vaya is not subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k). Vaya remits the total accrued interest to the provider in the calendar month following the claim payment. To determine if interest is due to the provider, a payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States mail and properly addressed to the provider, or, if not mailed, on the date of the EFT or other actual delivery of the payment to the provider. Any interest paid to a provider may not be paid with funds allocated to pay for health care services.

Payment Suspensions

Vaya will suspend claims payment to any provider in its network within one business day of receipt of a legally valid notice from NCDHHS that provider payment has been suspended for failing to submit documentation to NCDHHS or otherwise failing to meet NCDHHS requirements, to include dates of service after the effective date provided by NCDHHS. Vaya will reinstate payment to the provider upon notice that NCDHHS has received the requested information. If the provider does not provide the information within the allotted timeframe, NCDHHS will terminate the provider from the NC Medicaid program. Vaya is not liable for interest or penalties for late claims payment related to payment suspensions.

NCDHHS Termination as a Medicaid Provider

Vaya will remove any provider from the claims payment system and terminate the provider's contract within one business day of receipt of legally valid notice from NCDHHS that the provider is terminated as a Medicaid provider. This applies to all providers, regardless of network status. If Vaya has suspended provider payment, upon notice from NCDHHS that the provider is terminated from the NC Medicaid program, Vaya will release applicable claims and deny payment for dates of service after the date of termination. There are no appeal rights for a provider terminated or sanctioned, including suspension of payment, by NCDHHS.

Repayment of Funds Owed to Vaya or NCDHHS

You are required to pay back any overpayment identified through self-audit or by Vaya. Encounter claim(s) submitted to NCTracks that are rejected, denied, or disallowed by NCDHHS are deemed overpayments. The Vaya

Finance Department collaborates with legal counsel and the SIU to collect any identified overpayments. We reserve the right to pursue collection of funds owed to Vaya through any legal means.

The Social Security Act and your contract require you to notify us in writing of any Medicaid claims reimbursed by Vaya that must be repaid, whether due to fraud, waste, abuse, or error, within five days of identification of the improper reimbursement. You must remit the overpayment within 60 calendar days (if a deadline falls on a non-business day, the deadline shall be extended to the next business day) of identification of the improper reimbursement. You must either file a void claim or replacement claim. Upon receipt, Vaya will make adjustments that will appear on your next RA.

If Vaya determines you were reimbursed for a claim or portion of a claim that should be disallowed because of an error or omission unrelated to fraud, waste, or abuse, including encounter claims denied in NCTracks, we will readjudicate such claims and recoup the overpayment from your claims payments. It is the provider's responsibility to update any and all address changes related to claims, including service sites and billing office locations, in NCTracks. The RA will identify any such adjudication or recoupment. There is no right to request reconsideration when claims are disallowed due to 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 the controlling authority, you must remit the amount owed within 30 calendar days of the notice, unless you timely submit a provider appeal as outlined in Section 11 of this manual or request in good faith a payment plan. Providers must submit completed appeal form to the address specified in the notification letter/form, within 30 calendar days from the date of the letter informing them of Vaya's intended action. If you fail to timely file a provider appeal or fail to timely submit requested financials and/or agree to a payment plan within a reasonable time after requesting a 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 require a signed agreement and may require a promissory note and security.

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

SECTION 10
Treatment Coordination and Discharge Planning Requirements

Discharge planning for behavioral health, I/DD, and TBI services begins at the time of the initial assessment and is an integral part of every individual's treatment plan, regardless of the level of care being delivered. The discharge planning process includes use of the member's/recipient'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 supports, when appropriate, to help the individual function in the community. Involvement of family members and other identified supports, including primary care or community behavioral health providers, require the person's written consent.

Hospitals and facilities contracted with us must cooperate fully with Vaya's transition planning efforts, including coordinating with the individual's PCP, TCM provider, BHCH, and/or other community-based behavioral health provider, as well as participating in interdisciplinary team meetings facilitated by Vaya. Specific requirements include the following:

- Permit transition staff, including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator to engage in and help coordinate the discharge planning process.
- Notify Vaya of member/recipient admissions/pending discharges and contact the assigned TCM provider (if applicable) to include them in the discharge/transition planning process.
- Share relevant information (including the individual's current person-centered plan or care plan, initial and final discharge plans, and medical information, when applicable) with the transition/discharge planning team and the individual's care team, if applicable. If a member/recipient declines to permit access to Vaya or the provider, this must be documented in the medical record.
- Establish relationships with AMH+ practices and CMAs to facilitate care transitions.
- Regularly schedule treatment and transition planning meetings for individuals in 24-hour inpatient care.
- Provide Vaya, the individual's care manager, and their 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. If a member/recipient declines to permit notice to Vaya or the provider, this must be documented in the medical record.
- 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 an individual from inpatient care. If a member/recipient declines to permit notice to Vaya or the provider, this must be documented in the medical record.
- If preferred formulary medication was used previously and proven ineffective for the individual, request prior authorization for a non-preferred medication. Prescribers can request prior authorization for medications for Tailored Plan Medicaid members by calling our Pharmacy Service Line (1-800-540-6083) or submitting the

appropriate form found in the Provider Portal. The prior authorization process will include a review of the member's medical history and preferred treatment alternatives that can facilitate ongoing medication adherence and effective treatment.

- Once a discharge date is set for individuals receiving inpatient behavioral health treatment, schedule a follow-up appointment with the BHCH or designated community behavioral health service provider (if the individual has an active treatment relationship pre-dating admission) or request that Vaya's Member and Recipient Services Department do so. The appointment must be scheduled to occur within five days of discharge.
- At the time of discharge, provide the member/recipient, Vaya, the care manager (if applicable), and the assigned community behavioral health provider with the following critical discharge information:
    - Reason for hospitalization
    - Significant findings
    - Procedures and treatment provided
    - Admission and discharge diagnoses
    - Individual's demographic information
    - Individual's discharge condition (including level of risk to self/others)
    - Discharge medications and Medication Reconciliation Form (including dosage, amounts, and when refills are needed)
    - Recommended follow-up care (both medical and psychiatric)
    - Recommended revisions to individual's crisis plan (if any)
    - Name of discharging physician with contact information
    - Any other information requested by Vaya at the time of discharge

Additional transitional care management functions include:

- The development of a 90-day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the individual, facility staff, and the care team, that outlines how the individual will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.
    - The transition plan must be implemented upon discharge as an amendment to the person-centered plan or care plan.
    - To the extent feasible, the care manager should conduct care management comprehensive assessments to inform the transition plan.
    - The transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
    - Development of the transition plan is not required for all ED visits but may be developed according to the care manager's discretion.
    - The TCM provider must:
        - Communicate with and provide education to the individual and their caregivers and providers to promote understanding of the transition plan.
        - Help schedule transportation, in-home services, and follow-up outpatient visits with appropriate providers within seven calendar days post-discharge, unless required within a shorter timeframe.
        - Ensure the care manager follows up with the member within 48 hours of discharge.
        - Arrange to visit the member in the new care setting after discharge/transition.

  - Conduct a care management comprehensive assessment within 30 days of the discharge/transition or update the current assessment.
  - Update the member's person-centered plan or care plan in coordination with their care team within 90 days of the discharge/transition based on the results of the care management comprehensive assessment.
- For individuals with I/DD or TBI, Vaya will ensure the TCM provider conducts relevant transitional care management activities in the following "life transitions:"
    - A member is transitioning out of school-related services;
    - A member experiences life changes such as employment, retirement, or other life events;
    - A member has experienced the loss of a primary caregiver or a change of primary caregiver; and
    - A member is transitioning out of foster care.

Vaya submits its policies and procedures for transitional care management to NC Medicaid for approval, including our approach to working with individuals with LTSS needs, as part of our Care Management Policy.

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

SECTION 11
Provider Disputes

Policy Statement

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

Scope

This dispute resolution process does not apply to appeals filed by a member/recipient, LRP, or personal representative 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 managed through Vaya's member/recipient appeals process explained in Section 3 of this manual.

This dispute resolution process is available to both network and out-of-network (OON) providers.

CAN A PROVIDER APPEAL EVERY DISPUTE IT HAS WITH VAYA?

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

- Denial of a request to participate in the closed network;
- Decision not to renew or extend participation as a closed network provider beyond the terms of such provider's network contract(s);
- Denial of a request to add a site or service to an existing closed network contract;
- Decision not 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, or Report of Findings that does not change the provider's status within the Vaya 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 & Medicaid Services, known as CMS (Medicaid or Medicare fraud);
    - NC Medicaid Program Integrity or the Medicaid Investigations Division of the NC Department of Justice (Medicaid fraud);
    - NC DHSR (licensure or health care personnel registry violations);

- NC Division of MHDDSUS (summary suspension and/or revocation of authorization to receive public funding for the provision of behavioral health and I/DD services);
- County DSS (abuse, neglect, and exploitation);
- Provider accrediting bodies;
- Practitioner licensure or certification boards; or
- Law enforcement.

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, Medicaid, or a Medicaid managed care program in any state (including a PIHP operated by another LME/MCO);
- Immediate jeopardy finding issued by CMS;
- Action taken by NCDHHS 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 provider who wishes to initiate it in response to any of the following:

- Any Notice of Administrative Action, Overpayment, or Sanction issued by Vaya;
- An emergency contract suspension or suspension of referrals issued by Vaya's CMO to protect the life, health, safety, or welfare of any member/recipient;
- Final notification of a claim denial;
- Payment withholding of a 1/12 shadow claim payment regarding a State-funded services contract by and between Vaya and a provider; and
- Any other significant dispute that cannot be resolved informally and that has direct implications for the provider, unless excluded as described above.

Vaya will review any requests for provider appeals concerning disputes that do not obviously fall into a category listed above and determine whether the dispute is valid and timely. If the dispute is valid and timely, or if an extension to appeal is granted, an appeal panel review will typically be held within 14 days following the receipt of a complete appeal request, with notice sent within 30 days. If the due date falls on a day the Vaya administrative office is closed (holiday, weekend, inclement weather, etc.), the notice will be issued the next day the office is open. If the dispute is invalid or untimely, you will receive a written notification.

Provider Appeal (Reconsideration) Overview

Reconsideration is the provider's opportunity to present documents and information disputing the findings identified by Vaya. All documentation you wish to be considered must be submitted electronically at the same time the Provider Appeal Request Form is submitted. There are three tracks for provider appeals: administrative actions, provider sanctions, and claim denials. Each track offers a mechanism for you to request an appeal review

by a three-person panel that was not involved in the initial or prior decision of the subject of the dispute. Providers may request an appeal review by at least one level of panel review. For requests to appeal a sanction or claim denial, you may request review from a first- and second-level panel.

Provider sanctions appeal reviews 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 organizations, facilities, or hospitals, a qualified individual employed by a network provider that provides the same or similar services as the subject of the dispute and/or the provider initiating the appeal). Peer participation is a requirement of Vaya's accrediting body.

Provider sanction disputes that are considered **clinical** in nature and pertain to your professional conduct or competence include, but are 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/recipient; or
- Other professional conduct, including as required by laws, rules, regulations, contract requirements policy, or manual (e.g., failure to exercise professional judgment in disclosing therapeutic information).

Administrative action disputes that are considered **administrative or non-clinical** in nature and pertain to matters such as, but not limited to, the following:

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

Disputes found in favor of the 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 if Vaya believes continued reimbursement is likely to increase any overpayment amount due.

HOW DO I REQUEST AN APPEAL?

A Provider Appeal Request Form is included with any written notification of a Vaya administrative action or sanction, except for claim denials, which are discussed below. You must submit a signed, fully completed Provider Appeal Request Form with all documentation to support your position within 30 calendar days of the date of the applicable notification. The disputing practitioner or an authorized representative of a provider organized as a corporate entity must sign the form.

You must select the type of panel meeting you prefer (video conferencing, desk review) and identify all individuals you plan to bring to the meeting. You may submit only one appeal request per dispute or notice.

The form and all documents you wish to be reviewed with your reconsideration must be sent electronically to provider.appeals@vayahealth.com.

WHAT IS THE DEADLINE TO REQUEST AN APPEAL?

You have 30 days from the date of the applicable notice to request an appeal. We will consider our action final if a fully completed and signed request is not received at the address listed in the form by 5 p.m. on the 30th day following mailing of the notice. Vaya does not grant extensions of time for filing. It is your responsibility to ensure delivery and provide proof of submission, if needed.

What happens after I submit an appeal request?

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, we will send the notice to your legal counsel.

How do I submit additional documentation for consideration by the panel?

Any documentation you wish to be considered by a panel must be submitted electronically.

- For all provider appeals, documentation supporting the justification for your position must be submitted at the same time as the Provider Appeal Request Form.
- For appeals involving claim denials, documentation for the first-level review must be submitted with the appeal request. Documentation for the second-level review must be submitted at least five 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 appeals in person?

No. You may request that your panel meeting be conducted by video conferencing, or paper (desk) review. For appeal reviews specific to shadow claim disputes, a desk review is the only type of panel meeting available.

Is an appeal the same thing as mediation?

No. Each party will be given an equal opportunity to present relevant evidence to support their position. The panel will deliberate after the hearing, weigh the evidence, and make a decision regarding the items in dispute. The facilitator will advise both parties to address the panel and not each other.

How soon will the panel meeting be scheduled?

The panel meeting will be scheduled to occur no later than 14 calendar days after receipt of the request, unless there are documented extenuating circumstances for the provider or Vaya. If the last day for the review to be held falls on a day Vaya’s administrative office is closed (holiday, weekend, inclement weather, etc.), the meeting may be scheduled the next day the office is open.

Can I reschedule if needed?

Once scheduled, panel meetings will not be rescheduled unless there are documented extenuating circumstances, such as death, serious illness, severe inclement weather, or unavailability of a clinical peer. If you request a panel meeting be rescheduled, approval of the extension will depend on your signed agreement that you will not use our decision to reschedule the meeting as a basis to challenge the validity of the appeal decision.

If the appeal review is postponed or otherwise rescheduled due to extenuating circumstances, the documentation due date does not change, but you may be granted up to a 15-day extension on this deadline at the discretion of the panel facilitator.

Do I need an attorney?

We cannot make that decision for you. You may want to consider the amount or issue at stake. A Vaya attorney is usually present at all panel meetings, except for claims denial appeals. 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 individuals who will be present.

How long will the panel meeting last?

In general, the meeting will be limited to two hours, with additional time 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 notes.

What happens at a video conference 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 relevant documentation or laws, rules, regulations, or policies.

Throughout the presentations, the panel members 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 the agenda and role(s) of each person present were explained, all parties were given equal opportunity to present their information in a fair and equitable manner, and Vaya shared the anticipated timing for a written decision.

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 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's legal counsel may be present during the deliberation to answer legal questions. All three panel members must be present for a vote to take place, and determinations are reached by majority vote. Vaya's Executive Leadership Team (ELT) is authorized to overturn or revise the decision of any Vaya appeals panel.

Following panel deliberations, the facilitator issues a decision notice based on instruction from the panel or ELT and following review by Vaya legal counsel. You will receive the written decision via secure electronic

transmission no later than 14 days after the panel meeting, excluding official Vaya holidays, unless additional time is needed due to extenuating circumstances. The date of the decision letter is the date of the final decision by Vaya.

Are panel meetings confidential?

Vaya is a government entity subject to the NC Public Records Act, N.C.G.S. Chapter 132. While there are some exceptions (for example, sensitive information, protected health 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 NC Medicaid whenever we terminate or suspend a provider's participation in our network. However, to protect confidentiality, uphold professionalism, and preserve objectivity, appeals 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/recipient 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" in Section 11 of this manual, 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 an appeal to a second-level panel by 5 p.m. within 10 days of the date of the first-level decision. Otherwise, the sanction decision will be final.

Please note that Vaya will assess late payment penalties and monthly interest if you do not pay back an identified overpayment within 30 days after the issuance of a final overpayment decision.

How does the second-level panel process work?

The second-level panel will include different panel members, but otherwise the process is the same. Within 14 days from the date we receive a signed, complete, timely request for appeal of a first-level sanction decision, excluding official Vaya holidays, we will schedule a second-level panel, unless there are documented extenuating circumstances for you or Vaya. We will notify you in writing of the date and time of the scheduled panel meeting.

Please note that the second-level decision is final and may not be appealed further with Vaya.

Disputing Claim Denials

What is a claim denial?

This is 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. Vaya sends providers Notifications of Claim Denials via electronic remittance advice (RA) or other final notification of payment, payment denial, disallowance, payment adjustment, or notice of program or institutional reimbursement. You must submit any requests to appeal claim denials within 30 days from this notification (usually the RA).

Where can I find the Appeal Request Form?

The Level 1 Request for Appeal Review of Claim Denial Form ("Level 1 form") is available on the Vaya website or may be requested from a Vaya representative. The submitted form must include specifics about the claim(s),

including, but not limited to, the member's/recipient's name and record number, date of service, service code, claim header information, and all other relevant information.

Level 1 claim denial appeal forms must be submitted electronically to be considered valid. All requests should be sent to provider.appeals@vayahealth.com. If a signed, complete Level 1 form is not received within the required 30-day period, Vaya will deny the claim without further written notification. This decision is final.

When will a panel meeting be scheduled?

Level 1 requests entail a desk review process. Vaya will schedule a Level 1 Desk Review panel meeting to occur within 14 days, excluding official Vaya holidays, from the receipt of a signed, complete, and timely Level 1 form, unless there are documented extenuating circumstances for you or Vaya. If the Level 1 panel determines it does not have the information necessary to make a decision, the Level 1 decision will be pended until the additional information is received as requested. Based on the information available, the panel will issue a written decision to uphold, overturn, or adjust the original determination within 60 days from the date of the Level 1 Desk Review.

What if I disagree with the Level 1 decision?

If you are dissatisfied with the Level 1 panel decision, you can submit a written request for a Level 2 Appeal Review. The form to request a Level 2 appeal review will be attached to the Level 1 reconsideration decision.

You must submit a signed, complete Level 2 form within 30 days from the date of the Level 1 decision. In the Level 2 form, you must specify whether you will participate in the Level 2 reconsideration by video conference, in person, or by submitting additional documentation. If a signed, complete Level 2 form is not received within the required 30-day period, Vaya's decision is final without further written notification.

When will the Level 2 panel meeting be scheduled?

Vaya will schedule a Level 2 Appeal Review panel meeting within 30 days, excluding official Vaya holidays, from the receipt of a signed, complete, and timely Level 2 form, unless there are documented extenuating circumstances for you or Vaya. If you do not attend the Level 2 panel Review meeting (in person or via teleconference) or do not submit additional information with your Level 2 Appeal Review Request, the Level 2 panel meeting will not be held, and the Level 1 decision will become final.

If a Level 2 review is held, the Level 2 panel will issue a decision to uphold, overturn, or adjust the Level 1 Appeal Review decision based on the information available. The panel will issue a written decision within 14 days from the date of the Level 2 panel 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.

Provider Grievances (Complaints)

Any provider who is dissatisfied with Vaya has the right to file a complaint, called a grievance under Medicaid. A provider grievance is an expression of dissatisfaction either orally or in writing by or on behalf of a provider contracted with Vaya, the NEMT Broker, PBM subcontractor, or another subcontractor on Vaya's behalf.

Any provider may file a grievance for any issue or concern they have with Vaya or another Vaya network provider. Vaya encourages every provider organization to address concerns informally through our Provider Network

Operations or Claims departments, but this step is not required, and a formal grievance may be filed at any time. Vaya will address all grievances in a timely, fair, consistent manner.

Vaya follows a "No Wrong Door" approach for grievance submission. Providers may report concerns as follows:

- Electronically using the Vaya EthicsPoint portal (allows for anonymous reporting)
- Orally to any Vaya employee, who will then file the complaint in EthicsPoint on their behalf
- By calling the Vaya toll-free 24/7 Compliance Hotline at 1-866-916-4255 (allows for anonymous reporting)
- By calling the Vaya toll-free Member and Recipient Service Line at 1-800-962-9003
- By calling the Grievance Resolution and Incident Team (GRIT) at 1-800-893-6246, extension 1600.
- By emailing ResolutionTeam@vayahealth.com
- Via hand-delivery, fax, email, or mail to any Vaya administrative office location or staff member

Efforts to resolve a grievance may include, but are not limited to, one or more of the following:

- Phone interviews with the filer to obtain additional information or clarification;
- Consultation with Vaya staff, including the CMO or other licensed clinicians or subject matter experts;
- Provider record request and record review; and
- Phone interviews with individuals who have a legitimate role in the issue to be resolved.

Vaya makes every effort to resolve grievances within 30 days. Vaya will send a Notice of Resolution to the filer that identifies the efforts made to resolve the complaint, Vaya's findings, and any proposed resolution.

Medicaid Provider Ombudsman Service

As part of Medicaid Transformation, NC Medicaid created a provider ombudsman to represent the interests of the provider community. The ombudsman receives and responds to inquiries and complaints regarding health plans, offers resources, and helps providers resolve issues. Additionally, the ombudsman assists providers with HIE inquires related to NC HealthConnex connectivity compliance and the HIE hardship extension process.

To submit inquiries, concerns, or complaints to the provider ombudsman, call the Medicaid Managed Care Provider Ombudsman line at 1-**866-304-7062** or email Medicaid.ProviderOmbudsman@dhhs.nc.gov.

SECTION 12
Grievance/Complaint Investigation and Resolution Procedures

All network providers are required to implement and maintain an internal process to address any grievances, complaints, or concerns related to services provided. This process must be in writing, well-publicized and communicated to all members and recipients upon admission to treatment and upon request. Any unresolved grievances, complaints, or concerns, as well as any violations of member or recipient rights, should be reported to the Vaya Grievance Resolution and Incident Team (GRIT) by calling 1-800-893-6246, ext. 1600, and/or by contacting the appropriate state or federal official:

NCDHHS Customer Service Center:

- **Phone:** 1-800-662-7030 (English or Spanish)

NC Medicaid Managed Care Ombudsman Program (for Medicaid members):

- **Phone:** 1-877-201-3750 (from 8 a.m. to 5 p.m., every Monday through Friday, except for state holidays)
- **Website:** https://ncmedicaidombudsman.org

NCDHHS Office of Privacy and Security:

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

Office of the State Long Term Care Ombudsman:

- **Phone:** 919-855-3400
- **Fax:** 919-715-0364
- **Website:** http://www.ncdhhs.gov/aging/ombud.htm
- **Mailing address:** 2101 Mail Service Center, Raleigh, North Carolina 27699-2101

NC Division of Health Service Regulation (licensed facilities)

- **Complaint Hotline:** 1-800-624-3004 (within North Carolina) or 919-855-4500
- **Complaint Hotline Hours:** 9 a.m.-12 p.m. and 1 p.m.-4 p.m. weekdays, except holidays

- **Fax:** 919-715-7724
- **Mail:** 2711 Mail Service Center, Raleigh, NC 27699-2711
- **Online Reporting:** https://info.ncdhhs.gov/dhsr/ciu/filecomplaint.html

U.S. Department of Health and Human Services Office for Civil Rights

- **Phone:** 1-800-368-1019
- **TDD toll-free:** 1-800-537-7697
- **Address:** 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
- **Email:** OCRPrivacy@hhs.gov

Vaya members and recipients also can file a grievance/complaint directly with Vaya about any matter other than a Medicaid adverse benefit determination or State-funded service authorization decision, either verbally or in writing. As a provider, you must publicize the process for contacting Vaya to report a grievance, complaint, concern, or potential rights violation:

- **Phone:** Call the Member and Recipient Service Line at 1-800-962-9003
- **Phone:** Call the Vaya Compliance Hotline at 1-866-916-4255 (this option allows for anonymous reporting)
- **Mail:** Vaya Health, Attn: Grievance Resolution and Incident Team, 200 Ridgefield Court, Suite 218, Asheville NC 28806
- **Email:** ResolutionTeam@vayahealth.com
- **Online through EthicsPoint:** vayahealth.ethicspoint.com (this option allows for anonymous reporting). EthicsPoint, an online compliance intake platform, is used as a compliance concern and complaint/grievance reporting mechanism for members/recipients, community stakeholders, providers, and Vaya staff. The EthicsPoint platform assigns an individualized report key to each case, as well as a password, which must be maintained by the submitter, as staff at Vaya do not have access to update or retrieve passwords.

We frequently receive anonymous complaints. Occasionally, we may receive a grievance/complaint about a network provider from one of your employees. We will not share the employee's 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/complaints is strictly prohibited.** Regardless of the source, we take all grievances and complaints very seriously and strive to resolve them to the best of our ability. Categories of grievances and complaints we receive include concerns about:

- Quality of care
- Access
- Attitude/service
- Billing/financial
- Quality of practitioner office site

If we receive a grievance or complaint about a network provider, our first step is usually to send a written request for more information and try to resolve the issue, unless: (1) the grievance or complaint involves an allegation of fraud, in which case the SIU will be notified; or (2) the grievance or complaint involves serious health and safety issues, in which case the CMO will be notified and take immediate action as determined necessary. You must keep documentation on all grievances or complaints you receive, including the date received, summary of the concern, and resolution information. Network providers are required to respond to requests for information from Vaya

within 10 days of a request for information. If you do not respond within this timeframe, Vaya will make a decision about the grievance or complaint without your input, and you may be referred for follow-up and potential sanction.

Based on the nature of grievances and complaints we receive, Vaya also may choose to investigate a network provider or make a referral to another agency, such as DHSR (for licensed facilities). Investigations may be announced or unannounced. More information about investigations can be found in Section 13 of this manual.

Vaya makes every effort to resolve member grievances and recipient complaints within 30 days. Under federal law, we have up to 90 days to resolve a Medicaid grievance. Individuals who file a grievance or complaint receive written notification about the resolution and may appeal the findings. The appeal is reviewed internally by an appropriate Vaya staff member or licensed clinician. Medicaid members may escalate a grievance to NCDHHS. There is no right to appeal a grievance to OAH.

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SECTION 13
Performance Improvement Procedures

Continuous Quality Improvement

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

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

Vaya must comply with numerous quality, satisfaction, performance indicator, and financial reporting requirements under our contracts with NC Medicaid and the Division of MHDDSUS, including requirements to measure and report indicators in the following domains: access, availability, quality of care, quality of services, appropriateness of services, system performance and satisfaction. Vaya may use your performance data for quality improvement activities when performance indicators are not met.

Vaya's Quality Management (QM) program uses a data-driven, outcomes-based Continuous Quality Improvement process that supports our goal to improve the health of North Carolinians. Through our QM and Performance Improvement (PI) program, Vaya applies a whole-person, coordinated approach to address both medical and non-medical drivers of health. We are proud to be a quality-driven organization that adopts continuous quality improvement (CQI) activities across all functional areas. Our comprehensive QM/PI program utilizes a Plan, Do, Study, Act (PDSA) methodology for clinical performance improvement projects (PIPs) that allows us to monitor performance and measure the effectiveness of initiatives. This is an established system for evaluating a change by planning, taking action, observing outcomes, analyzing results, and acting on what was learned. Vaya's QM Department partners with network providers to conduct clinical studies aimed at impacting the Quadruple Aim.

NCDHHS has developed a Medicaid Managed Care Quality Strategy to ensure the delivery of high-quality care and improved member and recipient outcomes. The strategy includes a set of quality metrics to assess performance and outcomes for LME/MCOs and Tailored Plan network providers. Vaya's PNO and QM departments support network providers during the initiation and implementation of interventions outlined in the Provider Support Plan as part of our Quality Assessment and Performance Improvement Program, which is updated annually. The Provider Support Plan details activities designed to advance the aims, goals, and objectives of our Quality

Assessment and Performance Improvement Program and lead to care improvement efforts at the practice and regional levels.

Vaya maintains a Quality Improvement Committee (QIC) that includes representatives from Vaya staff, members/recipients, and network providers. The QIC develops an annual Quality Management Plan with input and feedback from relevant stakeholders that includes a program description, evaluation, and workplan. Vaya makes this information available to network providers, practitioners, members/recipients, and stakeholders on the Vaya website. A printed copy of the plan is available upon request by emailing provider.info@vayahealth.com.

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

All network providers are required to continually self-assess services and operations, as well as develop and implement plans to improve outcomes for members/recipients. You are required to comply 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 toward goals. The assessment of need and determination of areas for improvement must be based on accurate, timely, and valid data. Vaya will evaluate your quality assurance (QA) and quality improvement (QI) system through focused monitoring and post-payment reviews.
2. Maintenance and submission of client rights committee minutes, if applicable.
3. Development and execution of an annual Quality Improvement Plan, which Vaya will evaluate through focused monitoring and post-payment reviews.
4. Participation in performance improvement projects required under our contracts with NCDHHS.
5. Reporting of incidents and follow-up, as needed.
6. Cooperation with Vaya's grievance/complaint, monitoring, and program integrity activities.
7. Active participation in provider and member/recipient satisfaction surveys.

Satisfaction Surveys

It is important to us that members/recipients, relatives, natural supports, and community stakeholders are satisfied with the services you provide and with our management of services. Vaya uses various methods to gather feedback on network provider performance, measure satisfaction, and obtain information used to identify needed services, training, or other quality improvement initiatives.

Monitoring to Ensure Quality of Care

Vaya is required to ensure network providers deliver high-quality services through monitoring member/recipient health and safety, conducting investigations, monitoring and resolving grievances and incidents, protecting member/recipient rights, ensuring provider qualification, assessing outcomes to determine efficacy of care, using evidence-based and best practices, and implementing preventive health initiatives. We are also charged with conducting compliance reviews and audits of medical records, administrative files, the physical environment, and other areas of network provider service delivery, including cultural competency reviews.

Vaya conducts health and safety site reviews, focused monitoring, post-payment reviews, complaint investigations, technical assistance, and health and safety checks of network providers. These activities may result in a plan of correction, overpayment, 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
- NC DHSR (licensure or health care personnel registry violations) or out-of-state licensure bodies
- NC Medicaid, the Division of MHDDSUS, or other LME/MCOs in North Carolina
- CMS (for potential fraud, waste, or abuse of Medicare funds)
- County DSS (member/recipient abuse, neglect, or exploitation)
- Provider accrediting bodies
- Practitioner licensure or certification boards
- Law enforcement

SITE REVIEWS OF UNLICENSED OR UNACCREDITED PROVIDERS

Site visits are conducted, when appropriate, by NC Medicaid's credentialing vendor. Network providers are required to meet the following standards, at a minimum, for office sites where members/recipients are seen:

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

Vaya site review specialists also complete reviews of unlicensed Alternative family Living (AFL) sites annually or when a provider requests to add or update a site in accordance with NCDHHS requirements.

POST-PAYMENT REVIEWS

Vaya evaluates network provider compliance and performance and evaluates clinical documentation to ensure services were provided appropriately, within established benchmarks and clinical guidelines, and are consistent with prior authorization (when required), relevant assessments, and the person-centered plan/treatment plan.

A post-payment review (PPR) is a process that involves a retrospective review of a sample of services and is typically conducted as a desk review, although reviews may occur on site. Vaya evaluates information from the member/recipient record (including assessment information, person-centered plan/treatment plan, and progress notes) against medical necessity criteria. The outcome of these reviews may indicate areas in which additional provider training is needed. Outcomes may also indicate services were provided that were not medically necessary or situations where a member/recipient did not receive appropriate services or needed care.

Because Vaya strives to be transparent throughout the PPR process:

- We will notify you of the scheduled review date in writing 21 to 28 calendar days prior to the review.
- We will notify you of the specific service records needed for the review no less than seven business days prior to the review.
- Reviews include opening and exit conferences. The exit conference includes discussion of any required follow-up by the network provider or Vaya. **You must present all information by the conclusion of the monitoring event.** Vaya will not use any additional information submitted after the review ends to change any established scores or out-of-compliance findings; however, we may consider it when implementing of a plan of correction (if required).
- We will notify you in writing of the results of the PPR within 15 days of completion of the review.

Vaya may issue a plan of correction, overpayment or adverse action for any out of compliance items and monitoring that reveals systemic compliance issues, or any quality of care or quality outcome concerns.

FOCUSED MONITORING

Vaya conducts focused provider monitoring for the following purposes:

- In response to significant indicators and/or reported trends that you may not be in compliance with the controlling authority identified in your contract, including, but not limited to, the Medicaid 1115 Demonstration Waiver; the Medicaid 1915(c) Waiver; NC Medicaid CCPs; Division of MHDDSUS service definitions; the RMDM; NC Administrative Code provisions governing delivery of publicly-funded healthcare services; and any other service-specific standards or contract or administrative requirements;
- To verify your contract compliance; and/or
- In response to priorities for compliance verification as identified by utilization, costs, and needs.

Focused monitoring may also be conducted in conjunction with NCDHHS divisions, other LME/MCOs, or other Vaya departments.

Focused monitoring may be conducted as a desk review or as an announced or unannounced site review. On-site reviews include opening and exit conferences, similar to a PPR. Any follow-up to be completed by the network provider or Vaya will be reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.**

Vaya will notify you in writing of the results of the focused monitoring within 15 days of completion of the review.

GRIEVANCE AND COMPLAINT INVESTIGATIONS

Vaya investigates any grievance or complaint 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 funds or fraud, waste, or abuse, it will be referred to the Vaya SIU. However, if information gathered during the informal resolution process suggests 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 for investigation. **Vaya also makes referrals for investigation in situations in which concerns require immediate on-site monitoring to assess member/recipient health and safety.**

Grievances/complaint investigations may be desk or on-site reviews and announced or unannounced. On-site reviews include opening and exit conferences, similar to a PPR. Any follow-up to be completed by the network provider or Vaya are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.**

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

WHAT IS A PLAN OF CORRECTION (POC)?

A POC is a written document you are required to develop in response to a Vaya Report of Findings that identifies a finding of non-compliance, a violation, or a deficiency. In a POC, you must specify how you will address each issue in need of correction. Vaya then reviews the POC to determine whether it adequately addresses all areas of concern. After approving a provider's POC, Vaya monitors the organization to ensure it implements and fully integrates the plan effectively, corrects all deficiencies, and is unlikely to repeat the offenses. We follow the process and timelines outlined in the NCDHHS Plan of Correction Policy. If a provider fails to submit or implement an acceptable POC or substantially minimize or eliminate deficiencies, Vaya may issue a sanction, up to and including terminating the provider's contract.

Suspensions for Health and Safety Reasons

Vaya is required by our accrediting body to suspend your contract if our CMO or another senior clinical staff person determines that a network provider may be engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any member or recipient. If Vaya decides to suspend referrals or your contract for health and safety reasons, we will make best efforts to notify you within one business day of the decision. The notice will include the basis for our determination, the effective date of the suspension, and instructions to discontinue the delivery of services until further notice and direct all members/ recipients in urgent need of services to contact Vaya's Member and Recipient Service Line at **1-800-962-9003.**

After issuing an emergency suspension notice, we 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.

- If the allegations are found to be unsubstantiated, we will immediately reinstate your contract retroactive to the date of suspension and send you a written notice to this effect.
- If any of the allegations are substantiated, Vaya will decide what further action to take, which may include full contract termination. Alternatively, we may, but are not required to, request that you develop a POC to rectify the issue. We will notify you in writing of the outcome of the investigation and any decision Vaya makes.

Adverse Actions

Vaya strives to ensure any adverse action we issue against a 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. If we receive notice from NCDHHS that a provider is terminated from the NC Medicaid program, we are required to remove the provider from our claims payment system, terminate their contract within one business day, and deny payment for dates of service after the Medicaid termination date. This applies to all providers, regardless of the provider's network status.

Vaya issues two categories of adverse action against network provider organizations and/or their owners or managing employees: administrative actions and sanctions.

WHAT IS AN ADMINISTRATIVE ACTION?

An administrative action does not result in a change to your status within the Vaya network. Some examples are:

- **Moratorium on the expansion of sites or services (closed network only):** Vaya temporarily prohibits you from applying to add additional sites or services to your contract or from responding to any Vaya procurement activity, including an RFP or RFI.
- **Payment suspension:** Vaya continues to process your authorizations and claims, but your payments are suspended (wholly or partially) for a designated time period not to exceed six months, unless payment suspension is required by 42 C.F.R. § 455.23, in which case the suspension period remains in effect until the Medicaid Investigations Division of the NC Department of Justice completes its investigation and/or legal proceedings related to the alleged fraud are completed.
- **Probation (increased monitoring):** Vaya places you on probation with increased monitoring for a specified period of time, not to exceed one year.

WHAT IS A SANCTION?

A sanction results in a change to your status within the Vaya network. Some examples are:

- **Contract suspension:** Vaya suspends your contract and prohibits you from participating in our network for a period of time, during which all members/recipients you serve are transitioned to other provider(s). This sanction includes a suspension to ensure health and safety issued by the CMO. During any period of suspension, Vaya will not make referrals, process new authorizations, or process claims for services delivered on or after the effective date of the suspension.
- **Exclusion from participation in the network:** Vaya terminates your contract and prohibits you from re-applying for participation in our provider network. Network providers who fail to provide the required written notice of network withdrawal and/or contract termination within the prescribed timeframe are automatically subject to exclusion by the Regulatory Compliance Committee.

- **Limiting or suspending referrals:** Vaya does not refer new/additional members/recipients to you, only makes a limited number or type of referrals, or only makes referrals for specific services and/or sites.
- **Site- or service-specific termination:** Vaya terminates one or more sites and/or services from your contract.
- **Full contract termination:** Vaya terminates your contract for all sites and services.

Vaya bases adverse action decisions on fair, impartial, and consistent factors, including, but not limited to, documentation or other evidence indicating 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 NC Medicaid CCPs and manuals or Division of MHDDSUS 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/recipients.

Automatic (Immediate) Termination

We may 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.
- NCDHHS or another state Medicaid agency suspends or terminates your participation in a state Medicaid or Children's Health Insurance Program (CHIP).
- Another LME/MCO suspends or terminates your participation in its network.
- CMS suspends or terminates your participation in the Medicare program.
- NCDHHS issues a payment suspension against you in accordance with 42 CFR § 455.23.
- NCDHHS issues a revocation of your ability to receive state or federal funding per 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. All notices will identify the nature and effective date of the adverse action, the basis for the decision, an explanation of how to initiate appeals process, and how and when to submit additional information. We send all initial notifications via electronic mail to the primary email contact on file with Vaya. If you do not signify acceptance of the email within one business day, we send another notification via trackable mail. For purposes of calculating the appeal timeframes described in the next section, we consider the notification received by you on the date of our initial attempted email delivery, regardless of whether you signify acceptance, unless we sent it to the wrong address based on a Vaya error, in which case the date we sent the notification to the correct email address will apply.

We are required to notify NC Medicaid monthly of any provider applications to join our network we deny and any provider contracts we terminate, as well as any action we take against a network provider for program integrity reasons. We share the same information with other North Carolina LME/MCOs and any applicable accrediting bodies or licensing boards.

Incident Reporting

Vaya is required to monitor certain types of incidents involving Category A and B providers of behavioral health, I/DD, and TBI services and other providers who operate in our region. An incident is an event that is not consistent with the routine operation of a facility or service or the routine care of a member/recipient and that is likely to lead to adverse effects upon a member/recipient. Incidents are classified into three categories based on severity. Network providers are required to document and maintain internal records of all Level I incidents, make those records available upon request, and submit a QM 11 Quarterly Provider Incident Report form by the 10th day of the month following the reporting period.

Category A and B providers are required to report all Level II and Level III incidents in the state's Incident Response Improvement System (IRIS) in accordance with 10A NCAC 27G .0604. Per your contract with Vaya and NC Administrative Code, you must give Vaya verbal notification of a member's/recipient's death within 24 hours for any member you have seen within 90 days prior to their death. Out-of-state providers who do not have access to IRIS must submit paper copies of the incident report to NCDHHS and to Vaya.

Network providers must have their own internal quality management process that ensures review, investigation, and follow-up for each incident that occurs. This process must include:

1. Periodic reviews of all incidents to monitor for trends and patterns
2. Strategies aimed at reducing/eliminating of trends/patterns
3. Documentation of efforts to improve and an evaluation of ongoing progress
4. Adherence to all mandatory reporting requirements

Within 24 hours of any Level III incident that occurs while the member involved is receiving their services, providers are required to initiate a formal internal review process and notify Vaya's GRIT by facsimile to 828-398-4407 or secure email to IncidentReport@vayahealth.com, or phone call to 1-800-893-6246, ext. 1600.

Vaya receives and tracks all incident reports filed in IRIS that involve Category A and B providers in our region. Upon receipt, we review incidents for completeness, appropriateness of interventions, and achievement of short- and long-term follow-up for the member/recipient and the provider's service system. If an incident reviewer determines corrections are needed, Vaya will email a request for corrections to the person who submitted the incident report. All requests must be returned in a timely manner. Non-compliance with requests and timelines may result in a Plan of Correction in accordance with Vaya's policies and procedures.

Vaya's Critical Incident Review Committee (CIRC), which is chaired by our CMO, reviews all member/recipient deaths and Level III incidents and may request additional documentation. You are required to cooperate with this process and submit records as requested. Providers are also required to develop and maintain a system for collecting and tracking documentation on any incident involving a member that occurs. If CIRC has concerns

related to the individual's care or services or your response to an incident, the committee will refer the matter for potential investigation.

GRIT is also responsible for receiving and responding to all grievance and complaints filed by or on behalf of a member/recipient as referenced in Section 12 of this manual.

For more information about IRIS and your reporting responsibilities, visit the NCDHHS IRIS webpage. For IRIS resources, including the Incident Response and Reporting Manual and NC IRIS Technical Manual, visit the Department's IRIS Resources webpage.

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SECTION 14
Member and Recipient Rights and Empowerment

The protection and promotion of member and recipient rights and empowerment is a crucial component of Vaya's service delivery system. Network providers must respect member/recipient rights, educate individuals on their rights, and support them in fully exercising their rights.

Member and Recipient Rights

Under the federal and state constitutions; N.C.G.S. Chapter 122C, Article 3; Division of MHDDSUS APSM 95-2: Client Rights Rules in Community Mental Health, Developmental Disabilities, and Substance Abuse Services; and other applicable federal and state laws, rules, and regulations, Vaya members and recipients have the following rights:

- To be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation, or gender identity and to be free from any form of discrimination prohibited by federal or state laws, rules, and regulations
- To be told where, when, and how to get the services they need from Vaya
- To be told by treating providers what is wrong, what can be done, and what will likely be the result, in language they can understand
- To be informed in advance of the benefits or risks of treatment choices and to receive a second opinion, at no cost to them
- To give approval of any treatment or plan for care after that plan has been fully explained to them
- To refuse care, except in a medical emergency or an involuntary commitment, and be told about risks of refusing care
- To get a copy of their medical record, talk about it with their PCP, and to ask, if needed, that their medical record be amended or corrected
- To confidentiality and to be sure that their medical record is private and will not be shared with anyone except as required by law, by contract, or with their approval
- To use the Vaya grievance or complaint process to settle complaints
- To contact the NC Medicaid Ombudsman if they feel they were not treated fairly ***(for Medicaid members)***
- To appoint someone they trust (relative, friend or lawyer) to speak for them if they are unable to speak for themselves about their care and treatment
- To receive considerate and respectful care that respects their dignity in a clean and safe environment free of unnecessary restraints
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

- To receive information in accordance with federal Medicaid requirements ***(for Medicaid members)***
- To humane care and freedom from mental and physical abuse, neglect, and exploitation
- To live as normally as possible while receiving care and treatment
- To be free from unwarranted searches of their person or seizure of their possessions
- To be free from unnecessary or excessive medication, which shall not be used for punishment, discipline, or staff convenience, and which shall be administered in accordance with accepted medical standards and only upon the order of a physician or other medical practitioner, as documented in their health record
- To report any suspected violation of their rights to the appropriate regulatory authority as outlined in N.C.G.S. § 131D-21 ***(for members/recipients who live in ACHs)***
- To freedom of speech and freedom of religious expression
- To exercise the same civil rights in the most natural, age-appropriate, and least restrictive environment possible
- To exercise the same rights as any other citizen, including the right to vote, marry, divorce, make a will, and buy, sell, and own property, unless they have been adjudicated incompetent
- To be free from the threat of unwarranted suspension or expulsion from treatment
- To participate in the development and periodic review of their written person-centered treatment or habilitation plan that builds on individual needs, strengths, and preferences
- To have an individualized treatment or habilitation plan implemented within 30 days of admission to any inpatient or residential facility
- To ask questions of Vaya or their treating providers at any point in the process and receive accurate information
- To participate in a candid discussion with their treatment providers about medically necessary treatment options and alternatives for the relevant diagnosis or condition, regardless of benefit coverage limitations
- To receive information on available treatment options and alternatives, presented in an appropriate way that they can understand
- To decide among relevant treatment options and express preferences about future treatment decisions, regardless of benefit coverage limitation
- To be informed of the cost of services at the first visit or during scheduling of the first appointment
- To receive written notification from Vaya about adverse decisions on requests for prior authorization
- To file an appeal with Vaya of the denial, reduction, suspension, or termination of a service and to request a State Fair Hearing ***(for Medicaid members)*** or appeal to the NC Division of ***MHDDSUS (for State-funded recipients)*** if they disagree with Vaya's final decision
- To receive interpretation or translation services and other accommodations needed for accessibility, free of charge
- To a current listing of network providers and access to a choice of providers from within the network, to the extent possible or required by law
- To receive information about Vaya, network providers, and member and recipient rights and responsibilities presented in a manner appropriate to their ability to understand
- To recommend changes to Vaya's policies and services. If they wish to do so, members and recipients should call the Member and Recipient Service Line at 1-800-849-6127 or write us at: Vaya Health, 200 Ridgefield Court, Suite 218, Asheville, NC 28806

- To receive a written notice from Vaya of any significant change that requires modifications to the North Carolina Medicaid State Plan, applicable Medicaid waivers, or Vaya's contracts with NC Medicaid at least 30 days before the intended effective date of the change ***(for Medicaid members)***
- To make instructions for mental health, substance use disorder, I/DD, or TBI treatment in advance to use if they become incapable of making such decisions. The forms used to do this are called advance directives

Vaya strictly prohibits retaliation by Vaya staff or network providers against any member or recipient who exercises any of the rights described in this section.

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

Rights of Individuals in 24-Hour Facilities

Members and recipients admitted to or living in 24-hour licensed facilities, including, but not limited to, mental health or I/DD group homes, ACHs, psychiatric hospitals, and state-operated health care facilities, have the rights listed above as well as the rights to:

- Receive necessary medical care if they are sick. If their insurance does not cover the cost, they will be responsible for payment.
- Receive a reasonable response to requests made to facility administration or staff
- Receive upon admission and during the stay a written statement of the services provided by the facility and the charges for these services.
- Be notified when the facility is issued a provisional (temporary) license or notice of revocation (reversal) of license by NCDHHS and the basis on which the provisional license or notice of revocation of license was issued. The responsible family member or guardian shall also be notified.
- Send and receive unopened mail and have access to writing material, postage and staff assistance if requested
- Contact and consult with an advocate
- Contact and see a lawyer, their own doctor, or other private professionals, at their own expense and at no cost to the facility
- Contact and consult with their parent or legal guardian at any time if they are under age 18
- Make and receive confidential telephone calls, at their own expense and at no cost to the facility
- Receive visitors between the hours of 8 a.m. and 9 p.m. Visiting hours must be available for at least six hours each day, two hours of which must be after 6 p.m. If the member or recipient is under age 18, visitors cannot interfere with school or treatment.
- Communicate and meet with individuals that want to communicate and meet with them (this may be under supervision if their treatment team believes it is necessary.
- Make visits outside the facility unless their person-centered plan indicates that this is not recommended or the member or recipient was committed to the facility while under order of commitment to an NC Department of Public Safety (DPS) correctional facility OR as the result of the member or recipient being charged with a violent crime, including a crime involving an assault with a deadly weapon, and found not guilty by reason of insanity or incapable of proceeding
- Be outside daily and have access to facilities and equipment for physical exercise several times a week
- Keep personal possessions and clothing, except those items that are prohibited by law

- Keep and spend a reasonable sum of their own money. If the facility is holding money for the member or recipient, they can examine the account at any time.
- Participate in religious worship if they choose
- Retain a driver's license, unless they are not of age or otherwise prohibited by law
- Not be transferred or discharged from a facility except for medical reasons, their welfare or another's welfare, nonpayment, or if mandated by state or federal law. Members and recipients must be given 30 days' notice except in cases of safety to themselves or others. They can appeal a transfer or discharge (according to rules by the Medical Care Commission) and can stay in the facility until resolution of the appeal.

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

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

Individuals living in state-operated health care facilities are afforded all state and federal civil rights, including rights under N.C.G.S. Chapter 122C, Article 3; the Individuals with Disabilities Education Act (IDEA); the Americans with Disabilities Act (ADA); the Rehabilitation Act; the Civil Rights of Institutionalized Persons Act (CRIPA); and Title VI of the Civil Rights Act. Consumer advocates are located in each state-operated health care facility and are available to individuals and their families 24 hours a day, seven days a week. Each state-operated health care facility also has a human rights committee that is appointed by the Secretary of NCDHHS. These committees work to protect the rights of the people being served by the facility. Consumer advocates are available to follow up on any matters that are of concern to the human rights committees.

Non-Discouragement

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

Informed Consent and Advocacy

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

- Advocate for medically necessary care or treatment options.

- Provide information the individuals need to decide among all relevant treatment options.
- Encourage the individual to participate in decisions regarding their health care and express preferences about future treatment decisions through advance directives and crisis plans.

You must obtain informed consent from members/recipients prior to starting any service or course of treatment. This means 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 the members/recipients in treatment team meetings and development of their service plan. Members and recipients 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, (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 or recipient is under age 18, is not emancipated, and the guardian or LRP gives permission.

Right to Privacy and Security

Vaya network providers must ensure the confidentiality, privacy and security of all member and recipient health records in accordance with the HIPAA, 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 all employees and contractors maintain the confidentiality of persons receiving services and other information received while providing services.

This means that network providers and their employees and contractors must not discuss, transmit, or narrate in any form any member or recipient information of a personal nature, medical or otherwise, except as authorized in writing by the member/recipient/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 and recipients, or that contain protected health or other sensitive information, 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 on the HHS website. We may ask to see a copy of your notice during an on-site review. Vaya's Notice of Privacy Practices is available on our website at vayahealth.com.

Rights of Minors

Please be aware that under North Carolina law, a minor (a person under age 18) has the right to agree to some treatments without their parent or guardian's consent, 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

Vaya network providers who operate 24-hour treatment facilities must provide members/recipients 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. Such providers must explain and provide a copy of these rules to members/recipients within 72 hours of admission. Please refer to Subchapter 27F of the 10A NC Administrative Code, Section .0100 through .0105, for more information about this requirement.

Guardianship

Individuals who cannot make and communicate important decisions about their personal and financial affairs may be declared incompetent and be assigned a guardian to help them exercise their rights. If you are serving someone who may need a guardian, you should talk to their family members about options or file an adult protective services report with the county DSS office. Guardianship does not necessarily mean the person loses all rights. It can be limited to protect those rights that are within the individual's comprehension and judgment. 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 health care, 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 in N.C.G.S. Chapter 35A. At minimum, you should be aware of the following provisions:

- N.C.G.S. § 35A-1201(5) states, "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 means that you must do your best to ensure that people you are serving who are adjudicated incompetent are included to the fullest extent possible in treatment team meetings and other venues where decisions about their 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, AFL homes, FCHs, ACHs, 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 behavioral health and I/DD 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 members/recipients 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 their affairs due to marked subnormal intelligence or mental illness, incompetency, condition, or disease

In addition to the NICS check, people 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 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 record 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 or care plan, as applicable, or on an emergency basis. "Prone" restraints or any techniques whereby the restrained individual will end up in a face-down position are entirely prohibited. If a restrictive intervention is used three or more times within a 30-day period or is used as a therapeutic treatment designed to reduce dangerous, aggressive, self-injurious, or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures, it must be included in the member's person-centered plan or care plan, as applicable, as a planned restrictive intervention. Otherwise, it must be reported to Vaya's Human Rights Committee and/or in the IRIS, as applicable. All restrictive interventions or devices utilized must comply with Article 3 of N.C.G.S. Chapter 122C.

Client Rights Committee

Organizations contracted to participate 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 the organization uses, 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 related to Vaya members. The Vaya HRC is responsible for the monitoring and oversight of provider client rights committee functions.

Advance Directives

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

The state of North Carolina has specific forms that can be used for individuals to create advanced directives, as well as resource documents to help members understand advance directives. Vaya supports the use of "Health Care Power of Attorney," "Advance Directive for a Natural Death: Living Will," "Advance Directive for Mental Health," and "Advance Directive – Expanded." These advance directives enable individuals to plan 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/recipients about the ability to create advance directives and assisting those who express the desire to create one. If you are helping a member/recipient complete an advance directive, 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.

When a member/recipient presents a valid advance directive, their provider must make it a part of the person's medical record. The attending provider must act in accordance with the advance directive if the person is found to be incapable, unless compliance is not consistent with generally accepted or best-practice standards of treatment to benefit the person, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the person is involuntarily committed to a 24-hour facility and undergoing treatment as provided by law. If the provider is unwilling to comply with all or part of the advance directive, they must notify the member/recipient and record the reason for noncompliance in the patient's medical record.

Accessibility and Cultural Humility

Vaya strives to practice both cultural competence and cultural humility. Cultural competence is the ability to work respectfully with people from diverse cultures, while recognizing one's own cultural biases. Cultural humility is the ability to recognize one's own limitations to avoid making assumptions about other cultures. Vaya developed a Cultural Competency Plan and requires network providers to develop and implement their own Cultural Competency Plan that is respectful and supportive of the cultural and diverse needs of members/ recipients, families, stakeholders, communities, and other agencies. Providers should practice person-centered thinking and deliver services in a culturally competent manner to all members/recipients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, sexual orientation and/or gender identity. The principles of cultural competence and cultural humility should guide your values, decisions, policies, clinical protocols, and established benchmarks and outcome measures.

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

Providers must provide Medicaid members with verbal and written information about locally available transportation resources offered by NC Medicaid, as well as referrals to available community services and supports. Providers also must ensure interpreter services are available by telephone or in person at no charge to the member/recipient or to Vaya. If at any time Vaya discovers a provider has charged a current or potential member/recipient for translation or interpreter services, Vaya will notify NCDHHS in writing within five business days. A provider may submit an enhanced rate request if the individual's interpretation or other special needs impose a cost burden on them, but Vaya does not guarantee approval of any rate enhancement request.

To develop cultural competence and cultural humility, 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 individual. 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/recipients, families, and natural supports should participate in decisions about the individual's care, to the greatest extent possible and in accordance with clinical appropriateness and confidentiality requirements.

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

INDIVIDUALLY

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

ORGANIZATIONALLY

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

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

Network providers are required to complete a Cultural Competence Self-Assessment Tool annually. Assessment areas include:

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

SECTION 15
Member and Recipient Cost-Sharing Requirements

Some Medicaid members may be required to pay a copay for certain physical health care services or prescriptions:

Copays for Medicaid Beneficiaries*

Service	Member Copay
Physicians Outpatient services Podiatrists	$4 per visit
Generic and brand prescriptions	$4 per script
Chiropractic Optical services/supplies	$4 per visit
Optometrists Non-emergency visits to the ED	$4 per visit

There are NO copays for the following people or services:

- Members under age 21/EPSDT services
- Services related to pregnancy, childbirth, and postpartum care – to include prenatal care
- Members receiving hospice care
- Federally recognized tribal members or members receiving services through Indian Health Services (IHS)
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- Children in foster care
- People living in an institution who are receiving coverage for cost of care
- Behavioral health and I/DD services
- Members enrolled in NC Innovations and NC TBI waiver programs
- Members enrolled in CAP/C and CAP/DA
- Members enrolled in LTSS
- Family Planning Services
- Services dually covered by Medicare and Medicaid

A provider cannot refuse to provide covered physical health care services Vaya has authorized if a Medicaid beneficiary cannot pay.

Vaya recipients do not have to make any payment or copay for State-funded services that Vaya has authorized for the individual.

SECTION 16
Provider Program Integrity Requirements

Health care fraud, waste, and abuse affect all of us and are estimated to account for up to 10% of annual health care expenditures in the United States. Vaya is responsible for preventing, monitoring, and guarding against fraud, waste, and abuse of public funds and ensuring all services and claims we pay comply with Controlling Authority and Generally Accepted Accounting Principles at the point of delivery and/or payment.

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

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

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

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

Fraud

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

Waste

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

Abuse

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

1. Overutilization of medical and health care 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, a failure to comply with requirements of certification, or failure to comply with the provisions of the claim form.

For more information, refer to the CMS Fraud Prevention Toolkit.

How to Report Suspected Fraud

You are required to establish a system or mechanism for your employees, contractors, and individuals receiving services to report potential fraud, waste, abuse, or violations of the FCA. You must also ensure that your employees, contractors, and individuals 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).
- Submit a report online at vayahealth.ethicspoint.com (allows for anonymous reporting).
- Call the NC Medicaid Fraud, Waste, and Program Abuse Tip Line at 1-877-362-8471.
- Call the U.S. Office of Inspector General's fraud hotline at 1-800-HHS-TIPS (1-800-447-8477).

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

Compliance with Other State and Federal Requirements

FALSE CLAIMS ACT

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

The 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 February 12, 2024, FCA civil penalties increased to between $13,946 and $ 27,894 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.

Network providers must publicize Vaya's Compliance Hotline (1-866-916-4255) for staff and members to report potential fraud, waste, or abuse. Provider employees are strongly encouraged to report any instance of anything they think might constitute potential fraud, waste, or abuse occurring at Vaya or by a network provider involving services reimbursed by Vaya. We offer a robust internal reporting process and evaluate all referrals and concerns that are reported. Each network provider must conduct self-audits and report any instances of fraud, waste or abuse discovered.

The Special Investigations Unit

Vaya's Special Investigation Unit (SIU) is tasked with investigating allegations of fraud, waste, or abuse. The SIU also conducts data mining and data analytics and systematically monitors paid claims to look for trends and patterns suggestive of fraud, waste, or abuse. If we determine that a complaint, allegation, or trend rises to potential fraud, we must forward the information and any evidence collected to NC Medicaid, which will determine whether the allegation is credible and whether to make a referral to the Medicaid Investigations Division (MID) of the N.C. Attorney General's Office. If we determine there is no potential fraud, but that waste or abuse is present, we will continue with our investigation. In making these determinations, we use the federal and state definitions and guidance described previously in this section.

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

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

The SIU will review the records and determine if any overpayment is due, which primarily includes a determination of whether the documentation submitted complies with requirements 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 3 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 may also help SIU review for compliance with coordination of benefits requirements, financial reports, financial statements, and adherence to accepted accounting practices.

There are times when a Vaya-initiated provider self-audit may correct areas of potential waste or abuse identified through an SIU investigation referral. This cooperative effort both protects the financial integrity of the Medicaid program and ensures proper payments to providers. Any overpayments a provider identifies during a Vaya-initiated self-audit are not subject to reconsideration. If a provider chooses not to participate in a Vaya-initiated self-audit, the SIU may initiate an investigation. The SIU may also determine an investigation is warranted at any point during a Vaya-initiated self-audit.

Recovery audit contractors (RACs) for the Medicaid program may also audit providers in our network and/or work collaboratively with Vaya to identify overpayments. NC Medicaid requires RACs to give Vaya prior written notice of such audits and the results of any audits as permitted by law.

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

The SIU may utilize the prepayment pending of claims while an investigation of billing anomalies is investigated or as a corrective action measure. In advance of prepayment, Vaya's Regulatory Compliance Committee (RCC) must approve prepayment review and the provider must be notified in writing (Prepayment Review Notification Letter). The process automatically pends the provider's claims so that a clinical medical record review can ensure the provider's documentation supports the claims billed prior to payment. Claims received without medical records will be denied and the provider will be instructed to resubmit the claim with records. Upon completion of the prepayment review, the claim is processed according to the clinical review recommendations. Vaya will send a monthly prepayment pended claim review status letter that includes a description of review findings to the provider. The SIU investigator will monitor the provider's billing accuracy while the provider is on prepayment review. When a provider's billing accuracy falls into compliance (as defined in the Prepayment Review Notification

Letter) for a minimum of one quarter, SIU management may remove the provider from prepayment review with the approval of the RCC. Vaya may take additional actions, up to and including contract termination, against providers that are noncompliant with the prepayment review.

SECTION 17
Prevention and Population Health Programs

Vaya takes a population-based approach to improving the overall health of Medicaid members and collaborates with community partners on targeted public health initiatives (e.g., opioid crisis, infant mortality, mental health awareness, nicotine use prevention/cessation). Our prevention and population health programs reflect the community needs our region's LHDs have identified in community health assessments. Vaya makes these programs available to all members, using multiple sources and pathways to identify members who are likely to benefit.

Alignment with Department Priorities

Vaya's prevention and population health programs align with the Department's larger public health goals and Quality Strategy. Department-identified priorities include the following:

- Diabetes (prevention and management)
- Asthma
- Obesity
- Hypertension
- Tobacco cessation
- Infant mortality
- Low birth weight
- Early childhood health and development
- Other prevention and population health management programs that encourage improved health and wellness among members (e.g., interventions that will improve functional status and quality of life among members with behavioral health issues, I/DD, or TBI)

Promoting Wellness and Prevention

Vaya's plan-based care managers promote wellness and prevention by educating members about and referring them to Vaya's prevention and population health programs and/or other programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation and self-help recovery, and other wellness services based on the member's needs and preferences. Network providers are encouraged to participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access and misuse of legal and

illegal substances (alcohol, tobacco, e-cigarettes, and other drugs) to improve member emotional health and well-being.

Vaya notifies TCM providers when one of their members is participating in a prevention and population health program. Vaya sends these notifications through the Provider Portal but may also send them via fax or mail, if needed.

For information about specific programs, please refer to Vaya's Prevention and Population Health Program Description, available on our Provider Central website.

Tobacco Cessation

Tobacco use is the top preventable cause of death among individuals with behavioral health disorders. Research shows people with co-occurring behavioral health and tobacco use disorders lose an average of 25 years of their lives due to tobacco use and represent half of the annual deaths from tobacco in the United States, despite representing only a quarter of the population. All Vaya members/recipients receive a handbook, which includes information about the health risks of tobacco use and w how to get help reducing or stopping tobacco use. The Tobacco Cessation page of Vaya's website also links to Quit for Life, which allows users to engage in active planning for their health. It includes a feature called "Create My Quit Plan," a tool to develop tobacco cessation plans.

For more information, including requirements for network providers, refer to Vaya's Tobacco Cessation Plan, available on our Provider Central website.

SECTION 18
The NC Innovations Waiver

This section provides a general overview of the NC Innovations Waiver and includes requirements specific to Innovations Waiver service providers. It is important that network providers develop relationships across the service system to treat the whole person, including learning more about treating individuals with co-occurring mental health/substance use and I/DD needs.

Innovations Waiver Frequently Asked Questions

WHAT IS THE NC INNOVATIONS WAIVER?

The NC Innovations Waiver is a Medicaid HCBS waiver that allows individuals with an I/DD to receive services in the community instead of institutions (including state facilities or ICF/IIDs). Innovations includes a variety of services and supports designed to integrate the participant into their community and help them be as independent as possible.

HOW DOES SOMEONE BECOME ELIGIBLE FOR INNOVATIONS WAIVER SERVICES?

NC Innovations is a capitated, or "slot-based" program, with the number of slots determined by the North Carolina General Assembly. NCDHHS allocates slots each fiscal year, and Vaya fills those slots and serves the allocated number of Innovations participants. Unfortunately, there is more demand for the program than there are available slots. Because of this, we also maintain an Innovations Waiver waitlist, 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 the participant's disability.

WHAT IS THE REGISTRY OF UNMET NEEDS?

The Registry of Unmet Needs is a list of persons who are considered potentially eligible for the NC Innovations Waiver. Vaya maintains the Registry of Unmet Needs in our region.

WHAT DOES POTENTIALLY ELIGIBLE MEAN?

To be considered potentially eligible for NC Innovations, a member must have documentation of an I/DD or a closely related condition other than a mental health condition, and information about the resulting impairment to adaptive functioning.

WHAT IS AN INTELLECTUAL DISABILITY?

Intellectual disability involves impairments of general mental abilities that impact adaptive functioning. Typically, this includes individuals with an intelligence quotient (IQ) of 70 or below that impacts abilities in the conceptual, social, and practical domains of adaptive functioning in a clinically significant way. Intellectual disability is

considered a chronic condition and must manifest during the developmental period, typically prior to age 22. It often co-occurs with other mental health conditions, such as depression, attention-deficit/hyperactivity disorder, and autism spectrum disorders.

WHAT DOES CLINICALLY SIGNIFICANT MEAN?

Clinically significant is defined as deficits in cognitive ability or adaptive function that are two standard deviations below what a typically developing person would score on standardized tests administered by psychologists. In 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 condition" refers to a severe, chronic disability attributable to cerebral palsy, epilepsy, or any condition, other than a mental health condition, found to be closely related to an intellectual disability because it impairs general intellectual functioning or adaptive behavior in a way similar to an intellectual disability. The condition must be chronic and manifest before age 22. There must be documentation that the person has substantial functional limitation in three of the six identified major life activities. Autism spectrum disorder is an example of a related condition when it is not co-occurring with an intellectual disability.

WHAT ARE THE SIX MAJOR LIFE ACTIVITIES?

1. Self-care (ability to take care of basic life needs, such as food, hygiene, and appearance)
2. Understanding and use of language (ability to both understand others and 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, or non-ambulatory)
5. Self-direction (managing one's social and personal life and the ability to make decisions necessary to protect one's life)
6. Capacity for independent living (age-appropriate ability to live without extraordinary assistance)

HOW LONG DO INDIVIDUALS WAIT FOR AN INNOVATIONS WAIVER SLOT?

There are currently more than 2,000 individuals waiting for NC Innovations Waiver services in Vaya's region. NCDHHS allocates Vaya a limited number of slots each year. The number of slots available varies based on several factors, including funds allocated by the NC General Assembly, current Innovations participants' lifespan and support needs, and geographic location. **Vaya cannot fund slots using our waiver savings or other non-Medicaid funds.** Therefore, it is difficult to predict the wait time for Innovations services. While on the waitlist, a person who is identified as potentially eligible may receive Medicaid "in lieu of" services (ILOS), Long-Term Community Supports (LTCS), State-funded I/DD services, and/or 1915(i) services such as Respite, Supported Employment, and Community Living and Supports.

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 like Home Modification and Respite, which are not within the scope of services traditionally covered by Medicaid.

WHEN DID NC INNOVATIONS START?

The NC Innovations Waiver was approved for use in five counties in 2008 as part of the Piedmont Behavioral Health 1915(b)/(c) waiver model. Outside of the five counties in which Innovations was approved in 2008, the state continued to operate under the CAP I/DD Waiver until the 1915(b)/(c) waiver model was expanded statewide in 2012. Vaya began administering Innovations Waiver services on July 1, 2012.

ARE THERE ANY GUIDELINES OR POLICES FOR THE INNOVATIONS WAIVER?

Innovations Waiver services requirements are detailed in NC Medicaid CCP No. 8P, available on the NCDHHS website. It is your responsibility to stay abreast of changes to CCPs. NCDHHS is responsible for interpreting Innovations Waiver requirements. Vaya does not have the authority to disregard Innovations Waiver requirements and must comply with the Waiver as written and approved by CMS.

WILL THERE BE ANY CHANGES TO THE INNOVATIONS WAIVER?

The Innovations Waiver has been amended several times and may be amended again. NC Medicaid posts all waiver amendments to their website for a period of public comment. CMS must approve all changes to the waiver.

DOES THE INNOVATIONS WAIVER CONTAIN SERVICE LIMITS?

Yes. Below is a summary of current limits. Note that some, but not all, limits may be exceeded for children under age 22 under the EPSDT benefit (discussed in Section 3 of this manual):

- The Innovations Waiver has a **$184,000** annual budget ceiling per participant, except for documented need for individuals receiving Supported Living Level 3. Any other request to exceed that limit will result in denial of the plan. If an individual's needs cannot be met under the $184,000 cost limit, they should be evaluated for referral and placement in an ICF/IID.
- Adults ages 22 and over who live in private homes cannot be authorized for more than 84 hours per week for any combination of Community Networking, Day Supports, Supported Employment, and/or Community Living and Support.
- Children under age 22 who live in private homes cannot be authorized for more than 54 hours per week during the school year, or 84 hours per week when school is not in session, for any combination of Community Networking, Day Supports, Supported Employment, and/or Community Living and Support. If the individual is age 18 or older and has graduated with a diploma (graduation with a degree/occupational course of study/GED indicating a standard course of study), they 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 Vaya for up to an additional 12 hours per day of Community Living and Support to allow for 24 hours per day of support. There are specific criteria for approval of this service, based on the individual's assessment results, and approval must be reviewed every 90 days.
- Adults ages 22 and over who receive Residential Supports cannot be authorized for more than 40 hours per week for any combination of Community Networking, Day Supports, and Supported Employment services.
- Children under age 22 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 and Supplies, as well as Home Modifications, are limited to expenditures of $50,000 over the duration of the Waiver.

Vehicle Modifications funds are limited to expenditures of $20,000 over the duration of the Waiver.

DO ALL WAIVER PARTICIPANTS RECEIVE CARE MANAGEMENT?

All waiver participants are eligible to receive TCM. If the participant opts out of TCM, Vaya provides I/DD care coordination services that include care plan development and monthly monitoring visits to ensure services are being delivered appropriately and in accordance with care plan and waiver requirements and to ensure the health and safety of the waiver participant. The care manager also reviews the care plan for Innovations Waiver compliance, medical necessity, the member's health and safety needs, and service utilization (which is to remain within approved service authorization limits). Most monitoring is done face-to-face, although telephonic monitoring may occur as needed. The care manager also works with the family/LRP and service provider to develop and submit a care plan during the participant's birth month.

IS RESPITE AVAILABLE UNDER THE INNOVATIONS 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 for 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 themselves and/or family members. Respite may be used 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 their primary residence at the same address. 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 cannot exceed the per diem rate for the average community ICF/IID. Respite is not available to individuals who reside in licensed facilities that are licensed as 5600B or 5600C. **Staff sleep time is not reimbursable.** If providing Nursing Respite, the worker must be a licensed RN or licensed LPN in North Carolina.

Emergent Need Respite beds serve as a temporary placement for adult individuals (ages 18 and older) with I/DD and/or co-occurring mental health or substance use disorders who are either being diverted from or needing to be discharged from a hospital/ED setting and who are deemed stable and ready for discharge. The beds should be a step-down from, or diversion to, a hospital. The site may also be used for individuals who live in group or family settings to maintain their current residential setting (and when Respite has been determined not available/appropriate). The Innovations participant's care manager must make the referral for Emergent Need Respite.

ARE THERE COPAYMENTS FOR INNOVATIONS WAIVER SERVICES?

No. Providers may not charge a copayment for services available through the Innovations Waiver.

CAN VAYA TERMINATE SOMEONE FROM THE INNOVATIONS WAIVER?

There are several reasons why Vaya might terminate a slot. For example, we may remove a participant from the Innovations Waiver if they do not meet the requirement of receiving at least one service per month. These services are authorized because they were deemed necessary to ensure the participant's health and safety. If they are not provided, we must consider whether the person remains eligible, being mindful of the long waitlist for services. We may also terminate a slot if the participant, LRP, or family member fails or refuses to comply with Innovations Waiver requirements, including, but not limited to, selecting a provider, monitoring of service delivery and health safety, and service plan development and implementation.

Innovations Provider Responsibilities

PRIOR AUTHORIZATION

All Innovations Waiver services, except for crisis services, require Vaya's prior approval. Innovations services providers work with a participant's care manager to obtain prior authorization.

- Innovations providers are required to actively participate in the development of the care plan by attending meetings scheduled by the care manager and/or the Innovations participant.
- A care plan must be developed at the time an individual is admitted. Services must be implemented within 45 days of care plan approval.
- A new care plan, to be implemented on the first day of the month following the individual's birth month, must be developed on an annual basis thereafter.
- The care plan is developed using a person-centered planning process and must verify a proper match between the participant's needs and the service and/or supports provided. All services paid and unpaid (including natural supports) should be reflected in the care plan. Care managers will never ask someone to sign a plan of care the member or family disagrees with, but they may provide education about Innovations Waiver limits.
- The care plan is signed by the care manager, the participant, and/or the LRP, if applicable. Other individuals who participate in the development of the care plan may sign, if desired.
- Upon completion, the care manager submits the care plan to the Vaya UM Team for approval. The UM Team reviews the care plan against medical necessity criteria and service definitions found in NC Medicaid CCP No. 8P. The care manager also completes and submits a SAR for each distinct service.
- Providers are responsible for ensuring Innovations Waiver services are authorized before they are provided. Providers must implement services on the effective date of the authorization within the parameters outlined in NC Medicaid CCP No. 8P.

PERSON-CENTERED PLANNING

All Innovations service providers are required to participate in the person-centered planning process leading to the development of the member's care plan. The results from the SIS® guide development of the care plan, which outlines long-range outcomes for the participant. The care manager, in collaboration with the person-centered planning team, is responsible for developing the long-range outcomes. The care manager helps the member develop the care plan, including explaining available service options, asking the member how long they want services to be provided, and ensuring the proposed care plan requests authorization for each service at the member's requested duration during the care plan year.

Any requests for authorization of services must be consistent with and incorporate the participant's desires and be reflected in the participant's proposed care plan, including the desired service type, amount, and duration. The

Innovations service provider is responsible for developing the short-range goals that help the participant achieve the identified long-range outcomes. Each short-range goal must include the strategies and interventions that direct support professionals (DSPs) will use to help the participant achieve the goal. Innovations service providers are responsible for monitoring delivery of the services authorized in the approved care plan, including regularly reviewing and, as necessary, adjusting the short-range goals to help the participant succeed. Innovations service providers are also responsible for ensuring DSPs receive supervision as required by NC Medicaid CCP No. 8P.

SCHEDULING

Innovations Waiver participants are expected to leverage natural and community supports to foster development of stronger natural support networks and become less reliant on formal support systems. To achieve these outcomes, the waiver requires providers to ensure services are rendered according to an established schedule or plan. The care plan should indicate the average weekly hours of service and/or supports to be used and the total number of authorized units in an approval period. Vaya sends authorizations to the providers identified in the care plan as rendering identified services, with the Innovations service provider responsible for implementing the care plan by delivering services and/or supports.

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 waiver requirements, natural and community supports should be scheduled first, along with the participant's interests and habits. Formal supports should be built around natural and community supports. and the weekly schedule must take into consideration when a person learns best and when they need breaks. The weekly schedule informs the care plan and reflects the generally scheduled hours of service each day. It is a projection of the 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 or LRP – not for provider convenience. The Innovations service provider must document deviations. If there is to be a routine/ongoing deviation to the schedule due to changes in the participant's wants or needs, Vaya recommends the person-centered planning team update the weekly schedule to reflect the change to updates encourage better communication among all parties. Under no circumstance should the schedule be amended based on the needs of the provider organization. Unless there is a change to the total number of hours per year, the updated schedule does not need to be submitted to or approved by Vaya’s UM Team.

Once the schedule is established, only the participant or LRP may initiate changes. Post-payment reviews and focused monitoring reviews include audits of documentation, and Vaya may require a Plan of Correction if we identify deviations from the schedule. An overpayment may be issued if there is a deviation from the schedule in which billing occurred, but no services were provided and documented. Clear notation on grids, services notes, or a QP’s communication log serve as evidence of adherence to the intent of the Innovations Waiver.

DOCUMENTATION

Innovations service providers are required to document services as outlined in NC Medicaid CCP No. 8P, the NC Division of MHDDSUS Records Management and Documentation Manual, APSM 45-2, and as specified in this

manual. This includes, but is not limited to, adequate documentation of required staff training and service notes that include time in/time out.

BACK-UP STAFFING

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

Examples of back-up staffing Level 1 Incidents include, but are not limited to:

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

Service breaks are not considered Level 1 Incidents. Service breaks occur when a participant misses services for holidays, family vacations, weather conditions, illnesses, or scheduling conflicts that cause a brief interruption in services. The Innovations service provider must document service breaks, and the care manager must monitor them. Examples include, but are not limited to:

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

MONITORING

Vaya complies with all NC Innovations Waiver requirements, our contracts with NCDHHS, and the Department's Tailored Care Management model. Care managers monitor service delivery to verify:

- At least one service is used monthly, per Innovations Waiver requirements, except for members under age 21 with a diagnosis of autism spectrum disorder (ASD) who are actively engaged in a research-based intervention for the treatment of ASD
- Services are furnished in accordance with the care plan
- The member is offered a choice of Innovations Waiver service providers
- The member has access to services, and the services meet their needs
- Issues of health, safety, and wellbeing (e.g., rights restrictions, abuse, neglect, exploitation, back-up staffing) and non-Innovations Waiver service needs (e.g., medical care) are addressed and documented as appropriate
- Services are utilized correctly (including underutilization and exceeding authorization)
- Management of Individual and Family Directed Services funds (if applicable) are not exceeded
- The member is satisfied with the services rendered

Monitoring services and plan implementation provides opportunities to collaborate and enhance services and supports, helps the provider identify potential issues, and can identify areas of needed technical assistance. Following monitoring visits, the care manager reviews any issues with the provider and may request clarification prior to making recommendations. The care manager proactively offers assistance to help the provider meet positive outcomes for the member through multiple avenues (e.g., taking an issue to the member's care team, alerting the provider to training, offering technical assistance, brainstorming together to creatively meet member needs). If these efforts are unsuccessful or if the issue persists, the care manager makes a referral for investigation to the Vaya Provider Quality Assurance Team and documents each attempt to resolve an issue or provide education.

Guidance for Using Protective Devices

Because Innovations Waiver services are HCBS provided to individuals who would otherwise receive services in an institution, many rules for waiver service providers are written for facilities. This can cause confusion for individuals receiving, providing, and monitoring waiver services. This section aims to clarify how providers should apply rules about protective devices to 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 who are self-injurious. Vaya must ensure protective devices are monitored in accordance with 10A NCAC 27E .0105. Sometimes, a protective device is used to control an individual's behavior, which constitutes a restrictive intervention and must be monitored in accordance with 10A NCAC 27E .0104. Vaya contracts require all provider organizations to have a client rights committee in accordance with 10A NCAC 27G .0504. To ensure adherence to these rules, we require the following for all Innovations Waiver participants:

1. During care plan development, the team must consider all material supports the participant needs to live successfully in their community and document them in "Section B – Material Supports of the Risk/Support Needs Assessment." The care team must identify supports as either a protective device or behavioral control in the medical/behavioral "What others need to know to best support me" section of the care plan.
2. If a material support is identified as a protective device, the provider's client rights committee must review the support annually in conjunction with development of the care plan.
3. If any care plan team member expresses concern the material support is being used for behavioral control, the provider's client rights committee must review the support in accordance with 10A NCAC 27E .0104.

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

Relative as Direct Support Employee (RADSE)

There are times when it is necessary for relatives/LRPs (relatives) who share a home with the participant to provide paid supports to ensure the member can remain in the home and community of their choice, particularly in more rural communities. For this reason, NC Medicaid CCP No. 8P allows Innovations service providers to employ relatives to deliver Community Living and Supports and Supported Living within specific parameters. A relative is defined as an individual related by blood or marriage to the participant but does not include a minor child's biological or adoptive parents, a minor child's stepparents, or a participant's spouse. Participants receiving Residential Supports are regarded as having an out-of-home placement and therefore are not covered under the Innovations Waiver RADSE policy.

Having relatives provide paid supports is not the preferred option for adult waiver participants. To minimize the potential for conflicts of interest, respect member choice, and help ensure robust community integration, the best practice is for relatives to be just that – relatives – and provide the same natural supports they would for any family member. When considering a RADSE, family members and employing providers should ask:

- Is this about the participant's wishes, desires, and needs, is it about supplementing a family member's income, or is this about lack of available direct care workers?
- As an adult, is it appropriate or best for the participant to be with mom and dad throughout the day?
- If a family member supports an individual from birth onward into adulthood, does the individual learn to adapt to different people and increase their 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 service providers must obtain prior written approval from Vaya before employing a relative to deliver services to a waiver participant under the following circumstances:

- A new or continuing RADSE wishes to provide more than 40 total hours per week of Innovations services to a participant residing in the same home (e.g., a RADSE provides 45 hours of CLS/week to the participant)
- Multiple RADSEs wish to provide a combined total of more than 40 hours per week of Innovations services to a participant residing in the same home (e.g., RADSE A provides 25 hours of CLS/week to the participant and RADSE B provides 20 hours of CLS/week to the same participant, for a combined total of 45 hours of CLS/week)

- A new or continuing RADSE wishes to provide more than 40 total hours per week of Innovations services to multiple participants residing in the same home (e.g., a 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 in which 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 require documented efforts of attempts to find DSPs through multiple Innovations service providers. 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 ensure the participant's health and welfare.

A provider employing a RADSE to provide 40 or fewer hours per week of CLS to a waiver beneficiary is not required to obtain prior approval, but the provider must report the RADSE to the participant's care manager and ensure the paid supports section of the care plan and Section A of the Risk/Supports and Needs Assessment include the following information:

- The name of the RADSE
- The relationship of the RADSE to the Innovations participant
- The number of hours per week of Innovations services the RADSE provides

The Innovations service provider must initiate the procedure for prior approval through DocuSign® at least five business days prior to a new RADSE requesting to provide services and then on an annual basis in conjunctions with the annual care plan, at least four calendar weeks prior to the start of the waiver participant's plan year, for a continuing RADSE. Please note approval in one year does not guarantee approval in subsequent years.

Complete instructions and the link for beginning the process is available on our Provider Central website. The form requires the Innovations service provider to enter all the information Vaya needs to approve or deny the request. Vaya will review the form for complete information and render a decision within 14 days. If the provider does not receive a timely response to its request, it is the provider's responsibility to follow up with Vaya's Provider Network Operations (PNO) Department to determine the status of the request.

Vaya reviews location information and attestations indicated on the request form and makes an authorization decision based on the information. If Vaya approves the RADSE, the provider will receive the approved DocuSign® form. If Vaya denies the RADSE, the provider will receive the denied DocuSign® form and a formal letter explaining 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 OAH has determined that RADSE decisions are not appealable, but you or the participant may file a grievance by calling the Member and Recipient Service Line at 1-800-962-9003.**

The Innovations service provider is responsible for communicating Vaya's RADSE decision to the affected participant and relative. It is important to remember that relatives who are DSPs are employees of the

Innovations service provider and must comply with all requirements applicable to provider staff. As outlined in NC Medicaid CCP No. 8P, the Innovations-qualified professional is required to provide supervision, which includes clear communication about RADSE authorization decisions.

Vaya reviews RADSE data quarterly and uses it to inform network development decisions. Vaya is invested in ensuring a quality network of Innovations service providers who, to the fullest extent possible, work toward increasing natural home and community connections for individuals with I/DD. Requests to employ relatives should be made only after all other options are exhausted.

If you have questions about RADSE requirements, email RADSE@vayahealth.com.

Alternative Family Living (AFL) Requirements

- The AFL provider must be an organization. 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) and health care personnel registry and criminal background checks for both primary and back-up staff.
- The AFL site must be the primary residence of the AFL caregiver(s) (includes couples or a single person) who receives reimbursement for cost of care.
- If the AFL caregiver serves more than one member or a member under age 18, the site must be licensed by DHSR. If the AFL serves a single individual at an unlicensed site, it cannot provide services to another member while licensure is pending.
- The AFL provider must have a Back-up Staffing Plan, and back-up staff must be the AFL provider's employees.
- The AFL provider and caregiver must cooperate with required annual Vaya health and safety reviews.
- The AFL provider must notify a member's care manager before moving the 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.
- The AFL provider must meet Vaya insurance requirements, including coverage for general liability, property, and automobile liability.
- The AFL provider must meet the controlling authority's documentation requirements for all service provision and have documentation readily available for review upon request.
- The AFL caregiver may not be a relative (by blood or marriage) of the member receiving services.
- A member may not receive Residential Supports while living in a private home with their relatives (by blood or marriage).

SECTION 19

Block Grant Requirements

Vaya and the NC Division of MHDDSUS monitor network providers receiving federal mental health and/or substance use block grant funds through Vaya to ensure they meet all federal block grant (FBG) requirements. Only nonprofit entities are eligible for FBG funds. For more information, refer to the NCDHHS Block Grant audit information available on the Department's website.

If you receive FBG funds, your organization must respond to all Vaya and Division of MHDDSUS standard reporting requirements and information requests about the provision of FBG services. You are also required to participate in annual training and ensure financial documentation is filed accurately and timely.

Please note the additional requirements below. Your organization is responsible for keeping track of the category(ies) under which your FBG funds fall and, as such, which requirements apply to your organization.

Mental Health Block Grant Requirements

Network providers must maintain the following for individuals, services, and/or programs funded by federal mental health block grant dollars:

- Evidence that individuals served with FBG funds have a principal or primary diagnosis of serious mental illness (SMI) or severe emotional disturbance (SED)
- Evidence of member 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
- A signed, valid consent for release of information in each medical record that includes an expiration date of no more than 12 months following signature, along with clear reference to the specific information to be released and 42 CFR Part 2 requirements, including specific language that prohibits re-disclosure of information relating to substance use issues
- Evidence that funds are used to provide access to services to underserved mental health populations, including individuals experiencing homelessness, 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
- A system and policies to prevent inappropriate disclosure of individual records

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Requirements

Note: This section includes general requirements applicable to all SUBG populations/programs, as well as requirements for specific populations and programs. Your contract with Vaya may include additional requirements 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.

Network providers must meet the requirements below for individuals, services, and/or programs funded by the SUBG program, as well as certain programs funded with State service dollars.

GENERAL REQUIREMENTS

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

Providers must:

- Complete a Comprehensive Clinical Assessment that includes the required elements of NC Medicaid CCP 8C for all individuals served.
- Complete a recommendation regarding target population/benefit plan consistent with NCTracks eligibility criteria for all individuals served.
- Utilize the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (Fourth Edition, 2023) 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, address any co-occurring mental health condition(s) as part of the treatment continuum.
- Include in each medical record a signed, valid consent for release of information that includes an expiration date of no more than 12 months following signature, along with clear reference to the specific information to be released and 42 CFR Part 2 requirements, including specific language that prohibits re-disclosure of information relating to substance use issues.
- Complete and document a connection or referral to a PCP and include evidence of a signed, valid consent for release of information to the PCP in the medical record if a referral was made.
- Complete a tuberculosis (TB) screening at the time of admission. If the screening indicates presence of TB symptoms, the individual's medical record must include evidence of documentation of symptoms and referral for appropriate follow-up testing and/or other services and counseling about TB. You must meet all state TB reporting requirements while adhering to federal and state confidentiality requirements.
- Prioritize admission for treatment as follows:
    - Pregnant injecting drug users
    - Pregnant substance users
    - Injecting drug users
    - All others
- Widely publicize the availability of treatment services for women and admission preference for pregnant individuals. This can include street outreach programs, ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas and frequent notification of

availability of such treatment that is distributed to the network of community-based organizations, health care providers, and social services agencies.

- 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.
- Maintain a secure system to protect individuals' records from inappropriate disclosure in connection with any activity supported through FBG funds.
- Have a drug-free workplace policy in effect.
- Complete initial and subsequent NC Treatment Outcomes and Program Performance System (NC-TOPPS) interviews at required intervals.

WOMEN'S SET-ASIDE FUNDING REQUIREMENTS

These services target pregnant women and/or women with dependent children, including women who are attempting to regain custody of their children. The following requirements must 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-TR substance use diagnosis.
- Primary medical care needs are addressed, including referral for prenatal care and, while women are receiving such services, childcare.
- For individuals with children, primary pediatric needs and therapeutic needs of the children are addressed, including, but not limited to, immunizations, developmental needs, abuse (sexual or physical), and neglect.
- Gender-specific substance use disorder treatment and other treatment therapeutic interventions are provided that may address issues of relationships, sexual and physical abuse, parenting, and childcare while women are receiving these services
- The provider must offer sufficient case management and transportation to ensure women and children have access to the services outlined above.
- The provider must ensure timely admission or referral to appropriate services.
- Members are assessed for pregnancy.
- The provider must implement active outreach programs and priority admissions directed toward pregnant women with a substance use disorder.
- The provider must maintain a 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 must be given to 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 the provider organization 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 individual and reduce risks of disease transmission. When appropriate, interim services shall include:

- Counseling and education about HIV and TB infection, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps to ensure HIV and TB transmission does not occur.
- Referrals for prenatal care and HIV and TB treatment services, if necessary.
- Counseling on the effects of alcohol and other drug use on a fetus.

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

- Priority admission must be given to everyone who requests and needs treatment for IV drug use. This means that IV drug users must be admitted to a program through the provider organization or referral to another appropriate program no more than 14 days after making the request for admission.
- If there is no such program with capacity to admit the individual, the individual must be admitted within 120 days after the date of such request. For these individuals, interim services, including referral for prenatal care (if indicated), must be made available no later than 48 hours after the request for admission and continue until they are admitted into treatment. At a minimum, interim services must include counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps to ensure HIV and TB transmission does not occur, as well as referral for HIV and TB treatment services, if necessary.
- For individuals in need of treatment for IV substance use who cannot be placed in comprehensive treatment within 14 days, the program must 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 waitlist and need not be admitted within the initial 120-day period. If the individual later requests treatment, and placement on a waitlist is necessary, interim services are to be provided, and placement in the treatment program must occur within 120 days of the latter request.
- If the program is at capacity for this population, the organization must establish a waitlist that includes a unique identifier for each IV drug user seeking treatment, including those receiving interim services while awaiting admission.
- The organization must notify Vaya and the Division of MHDDSUS 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:
  - Using outreach models that are scientifically sound or an approach that can be reasonably expected to be effective
  - Selecting, training, and supervising staff to provide outreach
  - Contacting, communicating with, and following up with high-risk substance users, their associates, and neighborhood residents
  - Promoting awareness among IV drug users about the relationship between IV drug use and communicable diseases, such as HIV
  - Recommending steps to ensure HIV transmission does not occur
  - Encouraging entry into treatment

PRIMARY PREVENTION SERVICES REQUIREMENTS

Primary prevention programs are directed at individuals who are not determined to require treatment for a substance use disorder. These programs aim to educate and counsel individuals about substance use disorders and provide activities to reduce the risk of substance use.

- Priority must be given to populations that are at risk of developing a pattern of substance use.
- The organization must ensure programs receiving priority develop community-based strategies to discourage use of alcoholic beverages and tobacco by individuals to whom it is unlawful to sell or distribute such beverages or products.
- The organization must develop and implement comprehensive prevention programs that include a broad array of prevention strategies directed at individuals not identified to need treatment.
- Services must include activities and services provided in a variety of settings for both the general population and sub-groups at high risk of substance use.
- In implementing these provisions, prevention providers must use a variety of the following defined strategies:
    - Information dissemination
    - Education
    - Alternatives
    - Problem identification and referral
    - Community-based processes
    - 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.

In addition, Vaya ensures a total of 48 hours of Synar Amendment activities are conducted every six months through all contracted prevention providers. Synar Amendment activities are those designed to reduce youth access to tobacco products through community collaboration, merchant education, law enforcement, and related activities or media/public relations. At the beginning of each fiscal year, Vaya notifies each contracted prevention provider of the number of required hours they must devote to Synar Amendment activities per six months.

WORK FIRST/CPS SUBSTANCE USE INITIATIVE REQUIREMENTS

This initiative serves the NCDHHS Work First Family Assistance Program, Food and Nutrition Services, and Child Protective Services referrals.

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

JUVENILE JUSTICE BEHAVIORAL HEALTH PARTNERSHIP (NC JJBH) REQUIREMENTS

- Each individual must meet the requirements of the designated target population/benefit plan of Child Substance Use Disorder.
- For uninsured individuals, the organization must require documentation of application for NC Medicaid.
- The organization must have a signed, valid consent for release of information with the DJJ for each child being served.

APPENDIX A

Summary of Medicaid Covered Services & Clinical Coverage Policies

The table below contains Medicaid services and associated Clinical Coverage Policies that will be managed by Vaya. Full details on the policies are available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Clinical Coverage Policy 15
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)

[1]North Carolina's Medicaid State Plan is available here: https://medicaid.ncdhhs.gov/document/state-plan-under- title-xix-social-security-act-medical-assistance-program. Medicaid clinical coverage policies are available here: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

[2] The Department reserves the right to update the clinical coverage policies for covered benefits.

| Summary of Medicaid Covered Services & Clinical Coverage Policies |

SERVICE	KEY REFERENCES[1,2]
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a
Chiropractic services	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Clinic services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. §440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments
Dietary Evaluation and Counseling and Medical Lactation Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Durable medical equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)I North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members
Family planning services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Federally qualified health center (FQHC) services	SSA, Title XIX, Section 1905(a)(2) (C) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Freestanding birth center services (when licensed or otherwise recognized by the State)	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
Gynecology	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions
Hearing Aids	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
HIV case management services	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management
Home health services	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. §440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.l, Pages 13, 13a- 13a.4

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 3A
Home infusion therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy
Hospice services	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services
ICF-IID services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Innovations waiver services	8P: North Carolina Innovations
Inpatient hospital services	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. §440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services
Inpatient psychiatric services for individuals under age 21	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services
Inpatient and Outpatient BH services	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: Mobile Crisis Management Diagnostic Assessment

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	Intensive-In-Home Services Multisystemic Therapy Child and Adolescent Day Treatment Partial Hospitalization Substance Abuse Intensive Outpatient Program Outpatient Opioid Treatment Programs NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility- Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-6: Community Support Team (CST) North Carolina Clinical Coverage Policy 8D- 1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D- 2: Residential Treatment Services NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 8G – Peer Supports NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH)
Laboratory and X-ray services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Service NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology Vaya Health Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services
Maternal Support Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
Non-emergent transportation to medical care	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 NC Medicaid Managed Care NEMT Policy Guidance
Nursing facility services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home
Occupational therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Office Based Opioid Treatment (OBOT)	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine- Naloxone
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Optometry services	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 441.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
Outpatient and residential BH services (only covered By Medicaid)	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	• Psychosocial Rehabilitation • Professional Treatment Services in a Facility Based Crisis System • Substance Abuse Comprehensive Outpatient Treatment Program • Substance Abuse Non-Medical Community Residential Treatment • Substance Abuse Medically Monitored Community Residential Treatment • Ambulatory Detoxification Services • Non-Hospital Medical Detoxification Services • Medically Supervised or Alcohol or Drug Abuse Treatment Center (ADATC) Detoxification • Community Support Team
Outpatient hospital services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Personal care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the- Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Physical therapy	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Physician services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. §440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.l, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1A- 27 Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty
Podiatry services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Prescription drugs and medication management	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The- Counter Products

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters Section V.B.2.iii. Pharmacy Benefits of the Contract
Private duty nursing services (PDN)	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age
Prosthetics, orthotics and supplies	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Reconstructive Surgery	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty
Respiratory care services	SSA, Title XIX, Section 1905(a)(20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services
Rural health clinic services (RHC)	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Services for individuals age 65 or older in an institution for mental disease (IMD)	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient BH Services
Speech, hearing and language disorder services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Tobacco cessation counseling for pregnant women	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Transplants and Related Services	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy NC Clinical Coverage Policy 11B-1, Lung Transplantation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device
Vision Services	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older

APPENDIX B

List of State-funded Behavioral Health, I/DD, and TBI Services

The tables below contain the list of State-funded behavioral health, I/DD, and TBI services managed by Vaya.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
All–Disability	1. Diagnostic assessment[22] 2. Facility based crisis for adults[23] 3. Inpatient BH services 4. Mobile crisis management 5. Outpatient services[24]	1. BH urgent care 2. Facility based crisis for children and adolescents
Adult Mental Health	1. Assertive community treatment (ACT)[25] 2. Assertive engagement 3. Case management[26] 4. Community support team (CST) 5. Peer Support Services[27] 6. Psychosocial rehabilitation	1. Partial hospitalization

[22] Diagnostic assessment may be provided through Telehealth.
[23] This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.
[24] The BH I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.
[25] The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients
[26] This service may include critical time intervention, case management, and resource intensive case management (RICM).
[27] Peer supports include individual and group services.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
	7. Mental health recovery residential services[28] 8. Individual placement and support-supported employment (IPS-SE)[29] 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management	
Child Mental Health	1. High fidelity wraparound (HFW)[30] 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental health day treatment
I/DD and TBI[31]	1. Residential Supports 2. Day Supports Group 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment13 6. Respite 7. Adult Day Vocational Programs (ADVP)	1. TBI long term residential rehabilitation services
Substance Use Disorder - Adult	1. Ambulatory detoxification 2. Assertive engagement 3. Case management[32] 4. Clinically managed population specific high intensity residential services[33] 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports[34]	1. Social setting detoxification services

[28] This category of services may include group living and supervised living among other services.
[29] The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at: https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4364
[30] The Department intends allocate funding for slots for HFW services.
[31] I/DD and TBI care management will only be provided by the BH I/DD Tailored Plan.
[32] This service may include critical time intervention, case management, and RICCM.
[33] The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.
[34] Peer supports include individual and group services.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
	8. Substance use residential services and supports[35] 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment) 15. Community Support Team 16. BH Comprehensive Case Management	
Substance Use Disorder - Child	1. Multi-systemic therapy 2. SAIOP 3. Substance use residential services and supports 4. High fidelity wraparound (HFW) 9 5. Assertive Engagement	1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite

APPENDIX C

List of Medicaid Behavioral Health, I/DD, and TBI Services Covered by Vaya

- Inpatient behavioral health services
- Outpatient behavioral health emergency room services
- Outpatient behavioral health services provided by direct-enrolled providers
- Psychological services in health departments and school-based health centers sponsored by health departments
- Peer supports
- Partial hospitalization
- Mobile crisis management
- Facility-based crisis services for children and adolescents
- Professional treatment services in facility-based crisis program
- Outpatient opioid treatment
- Ambulatory detoxification
- Research-based BH treatment for Autism Spectrum Disorder (ASD)
- Diagnostic assessment
- Non-hospital medical detoxification
- Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
- Residential treatment facility services
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services
- Psychiatric residential treatment facilities (PRTFs)
- Assertive community treatment (ACT)
- Community support team (CST) (includes tenancy supports)
- Psychosocial rehabilitation
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment program (SACOT)

- Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Early and periodic screening, diagnostic and treatment (EPSDT) services

1915(i) Services

- Supported employment
- Individual transition and support
- Respite
- Community living and supports
- Community transition

APPENDIX D

Provider Advisory Council Code of Ethics

Vaya Health Provider Advisory Council (PAC) Code of Ethics

PREAMBLE

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

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

PURPOSE

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

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

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

CORE VALUES

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

- **Integrity:** Provide accurate and truthful representation.

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

ETHICAL PRINCIPLES

The following broad-based principles are based on the Core Values . These principles set forth ideals to which all network providers should aspire.

VALUE: INTEGRITY
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/recipients 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
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
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 part of an approved and documented treatment

plan or use of a documented emergency procedure shall not be considered abuse. Neglect means the failure to provide care or services necessary to maintain the mental or physical health and wellbeing of the individual. Network providers will promptly report and thoroughly investigate all allegations of abuse, neglect, and exploitation. Under no circumstance will the support relationship between the program, staff, and individuals receiving services and/or their families or legal guardian be exploited. Exploitation is defined as the illegal or unauthorized use of a service user or a service user's resources for another person's profit, business, or advantage. Network providers will train staff to recognize and report any suspected incidents of abuse and neglect and exploitation.

VALUE: INDIVIDUAL VALUE, DIGNITY, AND DIVERSITY
ETHICAL PRINCIPLE:
Network providers will comply with all federal and state rules and laws related to confidentiality and protected health information, including but not limited to, N.C.G.S. 122C-52 through 122C-56; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the HIPAA final administrative simplification regulations codified at 45 CFR Parts 160, 162, and 164; and 42 CFR Part 2. Network providers will not discriminate in their relationships or services provided to individuals receiving supports, contractor, and colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability. Network providers will provide individuals and families a means of submitting grievances that is fair and impartial. Network providers will comply with N.C.G.S. § 35A-1201, which allows 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
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 standard means of advertising for hiring staff.

VALUE: SOCIAL CAPITAL
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 E

Acronyms and Glossary

Commonly Used Acronyms and Glossary of Terms

1/12 shadow claim payment	Also known as a capitation payment. This is a predetermined payment established by contract. It is disbursed to the provider in 12 monthly payments and is intended as a prepayment for state-funded capitation services. Providers submit claims to Vaya the same as a fee-for-service claim. Providers are not paid for individual capitated service claims; the claims serve as proof that a service was rendered.
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. 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
Adjudicate	A determination to pay or reject a claim
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 their 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.

Ancillary services	Services and supports designed to address social determinants of health, including but not limited to public welfare benefits such as Food and Nutrition Services (SNAP/food stamps), Work First (Temporary Assistance for Needy Families, or TANF), Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program, utility assistance, food banks, and housing.
Appeal	A request for review of an adverse benefit determination or other adverse decision
Authorized service	Medically necessary service pre-approved by Vaya
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 our screening, triage, and referral system.
Capitation	Also known as sub-capitation. A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof a service was rendered.
Care manager	Individual assigned to conduct care coordination functions described at 42 CFR § 438.208(c), including referral, linkage, treatment, and discharge planning
Catchment area or region	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,” “member/recipient,” “participant,” or “patient.” An individual receiving services funded by Vaya or as defined in N.C.G.S. § 122C-3 (6).
CMO	Chief Medical Officer (Vaya)
CMS-1500	Health insurance claim forms. The CMS-1500 form is the official standard Medicare and Medicaid health insurance claim form required by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services.
Community Alternatives Program for Children (CAP/C)	A North Carolina Medicaid 1915(c) waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs (#4141.R06.00)

Community Alternatives Program for Disabled Adults (CAP/DA)	A North Carolina Medicaid 1915(c) waiver program that allows older and disabled adults ages 18 and older to receive support services in their own home, as an alternative to nursing home placement (#0132.R07.00)
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
CSRA (formerly CSC)	The fiscal agent for NCDHHS that is responsible for NCTracks
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.
DSS	NC Division of Social Services or (county) Department of Social Services
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 NC Medicaid to add a 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

Historically Marginalized Populations	Individuals, groups, and communities that have historically and systematically been denied access to services, resources, and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression. Long-standing and well documented structural marginalization has resulted in poor health outcomes, economic disadvantage, and increased vulnerability to harm and adverse social, political, and economic outcomes. Historically marginalized populations are often identified based on their race, ethnicity, social economic status, geography, religion, language, sexual identity and disability status.
I/DD	Intellectual/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 NC Psychology Board or the NC Addictions Specialist Professional Practice Board. Examples also include licensure of facilities that provide behavioral health, I/DD, and/or TBI services by the NC Division of Health Service Regulation (DHSR). Licensure may apply to both individuals and facilities.
Local management entity (LME)	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 use 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.
Long-Term Services and Supports (LTSS)	Care provided in the home, in community-based settings, or in facilities; care for older adults and people with disabilities who need support because of age, physical, cognitive, developmental, or chronic health conditions, or other functional limitations that restrict their abilities to care for themselves; a wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living; and care management provided to individuals who, because of age, physical, cognitive, developmental, or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.
Managed benefit	Services that require authorization from Vaya Utilization Management (UM)
Managed care organization (MCO)	An umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, practitioners, and hospitals
Medication reconciliation	The process of identifying the most accurate list of all medications that the member is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. Must also include identifying non-prescribed items (e.g., supplements, homeopathic remedies).
NC DHB	NC Division of Health Benefits, also known as NC Medicaid

NC Division of MHDDSUS	NC Division of Mental Health, Developmental Disabilities, and Substance Use Services
NC Innovations Waiver	The North Carolina 1915(c) Home- and Community-Based Services Waiver for people with an I/DD
NC Medicaid	Preferred name for the NC Division of Health Benefits (DHB)
NC-SNAP	NC 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 START	NC Systematic Therapeutic Assessment, Respite, and Treatment. NC START provides prevention and intervention services to adults I/DD and complex behavioral health needs.
NC-TOPPS	NC Treatment Outcome Program Performance System. Refers to the program used by the NC Division of MHDDSUS 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 services who has a contract in effect for participation in the provider network to provide services to Vaya plan members.
NPI	National Provider Identifier; a unique 10-digit identification number issued to health care 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 plan member outside of the Vaya region
Out-of-network (OON) provider	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. 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.
Place of service (POS)	The facility or area where a service is rendered

Plan of care	A single, unified plan that addresses the Member's integrated care needs related to physical health, behavioral health, social determinants, and ancillary services and includes participation from all health care providers and other individuals/ organizations involved in the member's care. The plan of care must address all applicable social, civil, or legal requirements and does not negate a member's right to privacy under federal and state law. The plan of care may also be referred to as a person-centered plan, a care plan, or an Individual Support Plan (ISP).
Population health management	The use of aggregated data to identify, analyze, and impact specific health conditions, reduce disease prevalence and disparities for identified populations, improve outcomes, and reduce unnecessary costs through advocacy and investment in cost-effective strategies, including developing and implementing educational approaches and practice guidelines to improve clinical decision-making and use of evidence-based practices
Pregnancy Management Program (PMP)	A care program that encourages adoption of best practice prenatal, pregnancy, and perinatal care for Tailored Plan Medicaid members.
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
Program of All-Inclusive Care for the Elderly (PACE)	A federal program that provides a capitated benefit for individuals ages 55 and older who meet nursing facility level of care; features a comprehensive service delivery system and integrated Medicare and Medicaid financing
Re-adjudication	A claim that has completed the adjudication process that is queued for another adjudication in Vaya's Conduent HSP claims system. Process can be initiated on a claim-by-claim basis by claims specialist or in a batch re-adjudication.
Recoupment	A mechanism to begin recovery of an overpayment with or without advance official notice by reducing future payments to a provider
Referral Screening Verification Process (RSVP)	The process used to determine whether an individual who is referred to or seeking admission to an adult care home licensed under N.C.G.S. § 131D-2.4 is screened to determine whether the individual has a serious mental illness (SMI) or severe and persistent mental illness (SPMI) as defined by the state of North Carolina's 2012 settlement with the U.S. Department of Justice.
Remittance advice (RA)	A document outlining claims status and payment that includes approved claims, denied claims, sub-capitated claims, and recoupments (credit memos)

Risk stratification	Risk stratification is a process that helps identify members for care management or care coordination by integrating a range of data sources calculated by various predictive models and current condition indicators. At Vaya, the risk stratification process focuses on behavioral health while incorporating physical health information to create a whole-person-driven stratification process. Risk stratification output can be used to monitor overall population health, highlight areas of major concern, and monitor outcomes over time.
Service authorization request (SAR)	A request for authorization of services. If approved, a SAR becomes an authorization.
Service location	Any location where a member may obtain a covered service from a network provider
Social determinants of health (SDOH)	The World Health Organization defines social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. Also referred to as unmet health-related resource needs.
State Fair Hearing	The hearing or hearings conducted at the NC Office of Administrative Hearings (OAH) under NCGS § 108D-15 to resolve a dispute between a member and Vaya about an adverse benefit determination.
STR	Screening, triage, and referral
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.
TBI	Traumatic brain injury
TCM	Tailored Care Management
Third-party billing	Services billed to an insurance company, Medicare, or other third-party payor
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
Unmet health-related resource needs	See “Social determinants of health (SDOH)” entry.
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.

APPENDIX F

List of Revisions

Vaya may update this Provider Operations Manual once per quarter in the event of substantive updates or revisions that impact providers or Vaya business. Unless directed by the Department, Vaya will not update this Provider Operations Manual more than once per quarter. Submissions of this provider manual to the Department do not replace or eliminate the requirement to annually review and update the provider manual. Vaya will review and update this Provider Operations Manual no less than annually to reflect changes to applicable federal and state laws, rules, and regulations; NCDHHS, NC Medicaid, or Vaya policies, procedures, bulletins, guidelines, or manuals. Vaya will submit this manual to NC Medicaid for approval no later than July 1 each year. Prior to the annual update of this Provider Operations Manual, Vaya staff will review all changes with the Provider Advisory Council, and providers will have 30 days to email suggested revisions to Vaya at manuals@vayahealth.com. This email may also be used throughout the year for suggestions for improvements to the manual. Your input will make this Provider Operations Manual more useful for all providers.

Vaya will notify providers of any updates to this Provider Operations Manual via Provider Communication Bulletins, and providers are also responsible for checking our website regularly for updates on the Provider Manual page of our Provider Central website. This Provider Operations Manual must be updated within 15 days of notification or request by NC Medicaid, and corrections or revisions to any printed version shall be included in the next printing. Any substantive updates or revisions to this Provider Operations Manual must be approved by NC Medicaid within 15 days of the change and shall not be posted, printed, or enforced until approval has been received.

All future revisions to this manual will be listed here and will include a summary of the revision, section and page number of the revision, and date the revision was completed.

Revision History

- April 19, 2023, Section 6 page 100, addition of the following: Vaya is prohibited from contracting with providers who are not enrolled with the Department as NC Medicaid providers or state-funded Services providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.
- April 19, 2023, Section 6 page 102, addition that providers must be re-credentialed through the Provider Enrollment Process no less frequently than every five years.
- June 25, 2023, Section 3 page 17, addition noting that the PDL Review Meeting email address is only active during the 45-day comment period before PDL Review Panel meetings.
- June 25, 2023, Section 3 page 29, removed language that OAH appeals may not be filed orally.

- June 25, 2023, Section 6 page 105, removed language that Vaya will review and/or verify limited credential information prior to issuing an Out-of-Network agreement.
- June 25, 2023, Appendix E page 250, added language that Vaya has fifteen calendar days to return an updated version of the Provider Operations Manual if any revisions are requested by the Department during the review and approval process.
- June 25, 2023, Section 9 page 135, added the following language: Vaya must suspend claims payment to any provider in its network within one business day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise fail to meet Department requirements, to include dates of service after the effective date provided by the Department. Vaya will reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within the Department's allotted timeframes, the Department will terminate the provider from Medicaid. Vaya will not be liable for interest or penalties for late claim payment related to payment suspension.
- June 25, 2023, Section 9 page 136, added the following language: Vaya will remove any provider from the claim payment system, and terminate the provider's contract within one business day of receipt of notice from the Department that the provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status. If Vaya has suspended provider payment, upon notice by the Department that the provider is terminated from Medicaid, Vaya will release applicable claims and deny payment for dates of service after the date of termination from Medicaid. There are no appeal rights for a provider terminated or sanctioned, including suspension of payment, by the Department.
- June 25, 2023, Section 6 page 118, added the following language: Network providers and their employees must maintain and provide proof of licensure as required under the terms and conditions of their contract and as outlined in the State's Credentialing and Re-credentialing Policy.
- August 6, 2023, Section 6 page 100, added the following language: Vaya may terminate as provider from its Closed Network with or without cause. If this occurs, Vaya will provide written notice of the termination to the Network provider. At a minimum, the notice will include the following: reason for our decision; effective date of the termination: provider's right to appeal the decision; and how to request an appeal (please see Section 11 Provider Disputes of this manual for details).
- August 6, 2023, Section 12 page 153, amended language regarding Medicaid member grievances to the following: Medicaid members may escalate a grievance to the Department. There is no right to appeal a grievance to the OAH.
- July 1, 2024, significant revisions throughout Manual to reflect current Vaya operations, provider requirements, and member/recipient terminology in alignment with the launch of Vaya Total Care, Vaya's BH and I/DD Tailored Plan.