2565 Good Faith Provider Contracting

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Policy

It is the policy of Vaya Health (Vaya), to enter into a valid, legally appropriate, written, and signed agreement, in Good Faith, with each Vaya Network Provider [QI-2], in accordance with 42 CFR §438.214, Vaya's contract(s) with the NC Department of Health and Human Services (NCDHHS or Department), and Accreditation Body standards governing Network Management and Quality Improvement. The purpose of this Policy is to identify the standards by which Vaya concludes whether a Good Faith Effort has been made in negotiating/ executing a Network Contract with Applicants, to describe the applicable rates for Out-of-Network providers engaged in Vaya's good faith contracting process, and to outline the business process and timeframes by which new or amended Network Provider Agreements will be requested, developed, negotiated, issued, executed, stored, and tracked. Requests for written agreements with Out-Of-Network (OON) Providers must follow the process outlined in Vaya Policy 2386 Out of Network Authorizations and Contracting.

Scope

This Policy applies to all Medicaid health plans operated by Vaya – including the Medicaid Direct Prepaid Inpatient Health Plan (PIHP) and the Behavioral Health (BH) and Intellectual/ Developmental Disabilities (I/DD) Tailored Plan (Vaya Total Care)– pursuant to contracts with NCDHHS.

Definitions

Accreditation Body means National Committee for Quality Assurance (NCQA).

Alternative Payment Methodologies means a payment methodology under the Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM)

framework that is a Fee-for-Service (FFS) payment linked to quality and/or value, including foundational payment for infrastructure and operations, pay for reporting, and pay for performance payments, (HCP-LAN Category 2); includes shared savings and/or downside risk (HCP-LAN Category 3); is a condition-specific population-based payment, comprehensive population-based payment, or population-based integrated finance and delivery system payment (HCP-LAN Category 4); is a risk-based payment not linked to quality (HCP-LAN Category 3N); or is a capitated payment not linked to quality (HCP-LAN Category 4N). It also includes other non-FFS payment methodologies that include, but are not limited to, non-unit cost reimbursement invoice-based, sub-capitation, bundled rates, per member per month, or 1/12 allocation, in which the Network Provider may have additional or alternative financial responsibilities (such as the submission of shadow claims and invoices) other than FFS claims submission to be eligible for payment. Any source of funding is eligible for an alternative payment methodology. Outside of the context of value-based contracting, an alternative payment methodology also includes a Medicaid payment methodology that has "lesser of" logic, an alternative reimbursement amount from the applicable rate floor required by NC Medicaid, and/or alternative financial responsibilities other than FFS claims submission to be eligible for payment for medical claims. An alternative payment methodology utilizing alternative financial responsibilities other than FFS claims submissions for (a) critical access hospitals and hospitals designated as economically depressed counties by the most recent NC Department of Commerce report available at https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers shall be permissible after the first four years of the Tailored Plan Contract, and (b) for all other hospitals, including non-critical access hospitals located statewide shall be permissible after the first two years of the Tailored Plan Contract.

Applicant means, consistent with the definition in N.C.G.S. §108D-1(3), any provider of health care services who seeks to participate as a contracted provider in the Vaya Network for our Medicaid Direct PIHP and/or Tailored Plan.

Behavioral Health and Intellectual/ Developmental Disability (I/DD) Tailored Plan ("Tailored Plan") means as defined in N.C.G.S. §108D-1(4) and is a North Carolina Medicaid Managed Care health plan under which Vaya offers Medicaid physical health, Medicaid pharmacy (prescriptions), non-emergency transportation, Healthy Opportunities Pilot program, and Medicaid and State-funded behavioral health, intellectual/developmental disabilities (I/DD), and traumatic brain injuries (TBI) services, supplies, and items to enrolled members and/or recipients.

Closed Network means the limited network of Closed Network Providers. The Closed Network includes providers of some, but not all, behavioral health, I/DD, and TBI services Vaya manages under its Tailored Plan and Medicaid Direct PIHP operations.

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

Closed Network Provider means, in accordance with 42 CFR §438.2 and N.C.G.S. §108D-22, -23, and -26, an appropriately NCTracks enrolled provider, group of providers, or entity delivering Closed Network Services that has a Network Contract with Vaya and receives Medicaid or State funding directly or indirectly to order, refer, or render Closed Network Services and participate in the Closed Network.

Closed Network Service means:

1. For the Medicaid Direct PIHP: Any MH/SUD/IDD/TBI service, including *in lieu of* services, until July 1, 2025, or such earlier effective date reflected in a Medicaid Direct PIHP Contract amendment, when Closed Network Services will be as expressly listed in the Closed Network list of services attached to the Medicaid Direct PIHP Contract.
2. For the Tailored Plan: As consistent with N.C.G.S. §108D, Article 3, and regardless of funding source:
   A. All State funded services; and
   B. All MH/SUD/IDD/TBI Medicaid services, including Home and Community Based 1915(i) services and *in lieu of* services, with the following exceptions:
      I. Inpatient behavioral health services.
      II. Outpatient behavioral health emergency room services.
      III. Outpatient behavioral health services provided by direct-enrolled providers.
      IV. Mobile crisis management services.
      V. Facility-based crisis services for children and adolescents.
      VI. Professional treatment services in a facility-based crisis program.
      VII. Outpatient opioid treatment services.
      VIII. Ambulatory detoxification services.
      IX. Nonhospital medical detoxification services.
      X. Partial hospitalization.
      XI. Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization.
      XII. Research-based intensive behavioral health treatment.
      XIII. Diagnostic assessment services.
      XIV. Early and Periodic Screening, Diagnosis, and Treatment services.
      XV. Peer support services.

XVI. Behavioral health urgent care services.
XVII. Substance abuse comprehensive outpatient treatment program services.
XVIII. Substance abuse intensive outpatient program services.
XIX. Social settings detoxification services.
XX. Beginning July 1, 2025, or such earlier effective date reflected in a Managed Care Contract amendment: Any other BH/IDD/TBI service (including *in lieu of* services) not expressly listed in a Closed Network list of services attached to the Managed Care Contract.

Essential Provider means as defined in N.C.G.S. §108D-22(b), a Medicaid provider who, if, within a region defined by a reasonable access standard, either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

1. Federally qualified health centers,
2. Rural health centers,
3. Free clinics, and
4. Local health departments.

The Department does not classify State Veterans Homes as an Essential Provider under the NCDHHS Contracts, and therefore, they are not deemed to be an Essential Provider for the purpose of Vaya operations.

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

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

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

1. the application of Objective Quality Standards established by NCDHHS;
2. the application of mandatory contracting clauses required by NCDHHS and Accreditation Body;
3. the development and maintenance of an Open Network and a Closed Network that meet NCDHHS availability, accessibility, and quality goals and requirements;
4. the consideration of whether an Applicant or Network Provider refuses to accept Vaya's Network reimbursement rates, which shall not be lower than any applicable rate floor required by the applicable NCDHHS Contract unless mutually agreed to an Alternative Reimbursement Methodology;
5. the exclusion of any provider that is not currently enrolled in NC Medicaid consistent with provider, disclosure, screening, and enrollment requirements of 42 CFR Part 455 Subpart B and E and the applicable NCDHHS Contract or of any provider appearing on one of the Exclusion Lists;
6. the consideration of the responsiveness of a Closed Network Applicant or Open Network Applicant, including but not limited to Indian Health Care Providers, for an initial Network Contract or a Closed Network Provider or Open Network Provider seeking renewal or amendment of a Network Contract;
7. in the case of MH/SUD/IDD/TBI Services that are not Closed Network Services or Medical Services, the application of Vaya's policies applicable to contracting with any Open Network Applicant or renewal of a Network Contract with any Open Network Provider;
8. in the case of Pharmaceutical Services, the terms and conditions of the PBM Contract, as well as PBM's policies applicable to contracting with any Open Network Applicant or renewal of a Network Contract with any Open Network Provider, considering all facts and circumstances surrounding an Open Network Applicant's or renewing Open Network Provider's, as applicable, willingness to contract before determining that such an Open Network Applicant or renewing Open Network Provider has refused Vaya's or the PBM's contracting effort;
9. in the case of NEMT Services, the terms and conditions of the NEMT Contract, as well as the NEMT Broker's policies applicable to contracting with any Open Network Provider or renewal of a Network Contract with any Open Network Provider, considering all facts and circumstances surrounding an Open Network Applicant's or renewing Open Network Provider's, as applicable, willingness to contract before determining that such an Open Network Applicant or renewing Open Network Provider has refused Vaya's or the NEMT's contracting effort; and
10. in the case of Vision Services, the terms and conditions of the Vision Contract, as well as

the Vision Vendor's policies applicable to contracting with any Open Network Provider or renewal of a Network Contract with any Open Network Provider, considering all facts and circumstances surrounding an Open Network Applicant's or renewing Open Network Provider's, as applicable, willingness to contract before determining that such an Open Network Applicant or renewing Open Network Provider has refused Vaya's or the Vision Vendor's contracting effort.

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

Member includes the term "Enrollee" as referenced in 42 CFR Part 438 and also refers to any of the following:

1. As applicable to the Tailored Plan services delivered by a Network Provider:
   A. A Medicaid beneficiary whose Medicaid eligibility arises from residence in a county located within the Region and who is enrolled in the Tailored Plan; and
   B. A state-funded services recipient who is eligible for and enrolled in the Vaya state-funded benefit plan, including individuals who receive MH/SUD/IDD/TBI Services funded with state, county, and/or federal block grant dollars.
2. As applicable the Medicaid Direct PIHP services delivered by a Network Provider: A Medicaid beneficiary whose Medicaid eligibility arises from residence in a county located within the Region and who is enrolled in the Medicaid Direct PIHP.

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

NCDHHS Contract(s) means the Medicaid Direct PIHP Contract and/or the Tailored Plan Contract.

NC Medicaid Direct is North Carolina's health care program for NC Medicaid beneficiaries who are not enrolled in Managed Care. Vaya operates the **Medicaid Direct Prepaid Inpatient Health Plan (PIHP)** in its Region pursuant to a contract with NCDHHS and arranges for behavioral health (mental health and substance use disorder), I/DD, TBI, and other services and supports for certain Medicaid enrollees as authorized by CMS pursuant to 42 CFR §438.806(a).

Network is the Closed Network and Open Network collectively.

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

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

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

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

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

Objective Quality Standards mean the standards approved by the Department and provided to Vaya through the Provider Enrollment File (PEF) by which Vaya and/or Vaya's Subcontractor determines whether to contract with any Open Network Applicant or renew a Network Contract with any Open Network Provider for any non-Closed Network Service. The Objectivity Quality Standards include any applicable Department-required standards for implementing a Tobacco-Free Policy. Vaya shall apply the Objective Quality Standards to any Closed Network Service identified by NCDHHS pursuant to its authority set forth in N.C.G.S. §108D-23(c)(2) for the Tailored Plan and §108D-26(b) for the Medicaid Direct PIHP.

Open Network means the network of providers of Physical Health and other Open-Network Services that have contracted with Vaya or our Subcontractor to respectively furnish such services to Members. For behavioral health, I/DD, and TBI services identified by NCDHHS as Open Network to improve member access, Vaya shall accept all providers of those services that:

A. Meet Objective Quality Standards, and
B. Accept network rates, notwithstanding the requirement to operate a closed network.

Open Network Applicant means any non-Closed Network Services Applicant who seeks to participate in the Open Network.

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

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

Pharmaceutical Services are Medicaid pharmaceuticals or pharmacy services, including outpatient pharmacy, required to be covered by Vaya under the Tailored Plan Contract and do not constitute either Medical Services and/or MH/SUD/IDD/TBI Services.

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

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

Prepaid Health Plan or PHP means, as defined in N.C.G.S. §108D-1(30), a health plan that is under a capitated contract with the Department for the delivery of Medicaid services, or a Local Management Entity/ Managed Care Organization that is under a capitated PHP contract with the Department.

Prepaid Inpatient Health Plan or PIHP means a prepaid inpatient health plan, as defined in 42 CFR §438.2.

Region, also referred to as a Catchment Area, means the geographic part of the State of North Carolina served by Vaya pursuant to N.C.G.S. Chapter 122C and the NCDHHS Contract(s) consisting of Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rockingham, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey counties.

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

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

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

Vision Contract means the contract between Vaya and the Vision Vendor for the Vision Vendor's administration of Vision Services and provision of an Open Network of providers of Vision Services.

Vision Services: Vision health benefits arranged by the Vision Vendor and required to be covered by Vaya under the Tailored Plan Contract and constitute a type of Medical Services.

Vision Vendor means the entity to which Vaya delegates the administration of Vision Services and development and maintenance of an Open Network of providers of Vision Services pursuant to the terms and conditions of the Vision Contract.

Procedure

Section I: General Requirements

1. All contracts with Network Providers must be in writing.
2. All Network Contracts shall comply with all applicable federal and state laws, rules, and regulations, accreditation requirements, and payor program requirements including, but not limited to, all standard contractual provisions required by NCDHHS pursuant to the applicable NCDHHS Contract.
3. Vaya shall not reimburse any provider for services delivered in the absence of an executed Network Contract or OON Contract or valid extension thereof, unless as required by 42 CFR §438.114(c)(i) or as authorized by the Area Director and Chief Executive Officer (CEO), General Counsel and Chief Compliance Officer (General Counsel), Executive Vice President and Chief Financial Officer (CFO) or their respective designee.
4. Vaya and its Subcontractors do not offer or give any incentive to providers, monetary or otherwise, for withholding medically necessary services.
5. The Legal Department shall be responsible for development of Network Contract templates and all contract development, drafting, gathering, verification, routing, execution and tracking in accordance with this policy and procedure.
6. The Provider Network Operations (PNO) departments are responsible for development of Scopes of Work (SOWs), value-based performance incentives and penalties, performance standards, and other non-financial attachments to Network Contracts, subject to review by the General Counsel or designee.
7. The Finance department shall be responsible for conducting the pre-audit required by the Local Government Budget and Fiscal Control Act, N.C.G.S. Chapter 159, Article 3 ("Pre-Audit"), and for generating and approving any financial attachments to Network Contracts.
8. Vaya shall implement and maintain a contracts lifecycle management software platform (the "Platform") that captures the following data elements at minimum: Contractor name; the date(s) of all signatures and routing; the date on which the contract was executed by all parties; the date on which the provider welcome packet and enrollment notice were sent; the effective beginning and termination or expiration date of the contract; and any other reporting elements deemed necessary or advisable by the NCDHHS, an Accreditation Body, and/or Legal, PNO, External Review, or Performance Reporting.
9. Vaya staff who regularly utilize the Platform will be trained in its use by the Contracts Team, and the Contracts Team will be available to provide technical assistance on use of the Platform as needed.
10. All Vaya policies applicable to contracting with any Closed Network Applicant or renewal of a Network Contract with any Closed Network Provider, including, but not limited to, Policy 3057 Provider Credentialing, Re-credentialing, and Enrollment, Policy 2386 Out of Network Authorizations and Contracting, and Policy 2831 Selection and Retention of Providers , shall

be applied for contracting with Closed Network Applicants or renewing or extending the Network Contracts with Closed Network Providers.

11. In the case of Open Network Services, Good Faith must be exercised by Vaya in negotiating and executing: (i) a Network Contract with an Open Network Applicant, inclusive of Indian Health Care Providers (IHCPs), or (ii) the renewal or extension of a Network Contract with any Open Network Provider.
    A. If there is not a provider within Vaya's Network that meets the needs of a Member, NCDHHS will permit exceptions to network requirements in a time limited manner.
    B. If there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a "Tribal Provider Attestation" letter, which shall be submitted to NCDHHS as part of the Department's centralized credentialing process. DHB will share information about tribal providers with Vaya.
    C. Vaya may request approval for an alternative arrangement in contracting with an Essential Provider by submitting a written request to the Department with a copy of the request provided to the Essential Provider prior to implementing any alternative arrangement and prior to notifying an Essential Provider of an adverse contracting decision.
12. Vaya may execute a Network Provider Agreement with a provider prior to the provider's approval through NC Medicaid via NCTracks enrollment process for up to 120 days but will terminate any such agreement immediately upon notification from NCDHHS that the network provider cannot be enrolled or upon the expiration of the 120 days period without enrollment of the provider. In these instances, Vaya will notify all affected members, and the Claims Team may recoup claims from the provider following consultation with PNO and Legal Department leadership.
13. In the case of services that Vaya has subcontracted (e.g., PBM, NEMT, Vision), all such Subcontractors must exercise Good Faith in negotiating and executing: (i) Network Contract with an Open Network Applicant or (ii) the renewal of a Network Contract with any Open Network Provider.
    A. Vaya delegates Network contracting for Pharmaceutical Services to the PBM, NEMT Services to the NEMT Broker, and vision services to the Vision Vendor and requires the Subcontractor to make a Good Faith attempt to contract with any willing and eligible provider. In addition, Vaya requires the Subcontractor to make Good Faith attempts to contract with enough providers, including, but not limited to, IHCPs as defined by 42 CFR §438.14(a) to satisfy access requirements for Members eligible to use them while allowing out of network access to providers without penalty for Members eligible to use them.
    B. Vaya's contracts for PBM, Vision, and NEMT require the Subcontractor to make

network contracting decisions based upon the provider enrollment file data Vaya receives from NCDHHS and shares with the Subcontractor.

C. Vaya reviews the Subcontractor's contract template for network providers prior to contracting to ensure uniform billing and reimbursement requirements and prevent preferential treatment of Subcontractor owned or operated providers.

14. Pursuant to N.C.G.S. §143-48 and Executive Order 150 (1999), Vaya invites and strongly encourages network participation with businesses owned by minorities, women, disabled individuals, disabled business enterprises, and nonprofit work centers for the blind and severely disabled. Vaya shall make Good Faith efforts to seek out and pursue opportunities to utilize Historically Underutilized Business (HUB), as that term is defined in N.C.G.S. §143-128.4.
15. Upon contracting with Vaya, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the applicable Medicaid waiver(s) or statute. The organization must be established as a legally constituted entity capable of meeting all the requirements of the Tailored Plan or Medicaid Direct PIHP, as applicable.
16. Vaya shall make Good Faith efforts to contract with IHCPs and demonstrate that enough IHCPs are participating in its Network to ensure timely access to Pharmaceutical Services, Medical Services, and MH/SUD/IDD/TBI Services for the members of federally recognized tribes and other individuals eligible to receive services at IHS facilities.
17. Neither Vaya nor its PBM shall not deny a pharmacy the opportunity to participate in the Open Network as required by N.C.G.S. §58-51-37(c)(2). However, if a pharmacy fails to meet NCDHHS Objective Quality Standards, neither Vaya nor the PBM is required to contract with the non-compliant pharmacy.
18. Vaya will not require individual practitioners, as a condition of contracting with Vaya, to agree to participate or accept other products offered by Vaya, or its Subcontractors, nor shall Vaya, or its Subcontractors, automatically enroll the provider in any other product offered by Vaya, or its Subcontractors.
19. Using the applicable Network Contract template or Network Contract amendment template, Vaya will offer to contract with an Applicant or Network Provider in writing by sending the provider a contract or contract amendment to execute. The contract shall have the provisions described herein, including the standard provisions required to be included per the applicable NCDHHS Contract(s). Amendments will maintain the inclusion of any such required provisions.
20. If within thirty (30) days of the Applicant or Network Provider receiving a contract to execute, inclusive of all applicable Tailored Plan contracting provisions, they reject the offer to contract or fail to respond either verbally or in writing, Vaya shall consider the request for inclusion in the Network rejected by the Applicant or Network Provider. If good faith

discussions are ongoing, or the contract is under legal review, Vaya shall not consider the request rejected.

21. If the Applicant or Network Provider requests negotiation of the contract within 30 days from the date the Network Contract is sent, Vaya shall negotiate in Good Faith. However, if either of the following occur, Vaya shall consider the Applicant's or Network Provider's actions or inactions to be a rejection of Vaya's offer for them to be, or remain, a Network Provider and Vaya shall be deemed to have acted in Good Faith during the negotiations and shall be permitted to terminate negotiations:
    A. an Applicant or Network Provider who requests negotiation of the contract
        I. does not provide proposed edits to the contract within 30 days of the request to negotiate, unless a longer period is agreed to by Vaya, or
        II. is unresponsive to Vaya's negotiation efforts over a 90-day period with at least three outreach attempts; or
    B. in Vaya's opinion after three rounds of negotiations, including responses from both parties over a 90-day period, are completed, continued efforts to negotiate a contract would be unproductive or ineffective for the parties to reach an agreement on reimbursement rates or mandatory or reasonable contract language (e.g., demanding Vaya to do more than required, eight percent per diem interest for underpayments, etc.).
22. Termination of negotiations for the reasons described in this Policy at Section I.21.A. above, shall not be considered a declination of contracting by Vaya and therefore does not require appeal rights be given the provider.
23. Termination of negotiations for the reason described in in this Policy at Section I.21.B., above shall not be considered a declination of contracting by Vaya, however, the Applicant or Network Provider shall have the right to appeal Vaya's decision and Vaya shall provide a notice within the timeframe and containing the provisions set forth in Section V of this policy.
24. During contract negotiations with an Applicant or Network Provider, Vaya may, without NCDHHS's prior approval, make changes to a previously approved provider contract template, except for changes to the following standard provisions expressly required in the NCDHHS Contracts, and as amended in the NCDHHS Contracts from time to time, to be included in a Network Contract:
    A. Assignment: Provisions on assignment of the Network Contract must include that:
        I. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of Vaya.
        II. Vaya shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.

B. Government Funds: The Network Contract must include a statement that the funds used for provider payments are government funds.
C. Interpreting and Translation Services: The Network Contract must have provisions that indicate:
    I. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
    II. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.
    III. The provider shall report to Vaya, in a format and frequency to be determined by Vaya, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
D. Providers of Perinatal Care: For all Network Contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All Network Contracts with obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.
E. Specific to Tailored Plan only, all Network Contracts must include provisions required by the following attachments to the NCDHHS Contract:
    I. Advanced Medical Home Program Policy for Medicaid Members
    II. Pregnancy Management Program Policy for Medicaid Members
    III. Care Management for High-Risk Pregnancy Policy for Medicaid Members
    IV. Care Management for At-Risk Children Policy for Medicaid Members

25. During contract negotiations with an Applicant or Network Provider, Vaya will make changes to the following standard provisions previously approved in Vaya's provider contract template only when directed by NCDHHS or when necessary to reflect revisions to such provisions required by an amendment to the applicable NCDHHS Contract:
    A. Compliance with state and federal laws: The Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NCDHHS), and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the Vaya's contract with NCDHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

B. Hold Member Harmless: The Provider agrees to hold the Member harmless for charges for any covered service. The Provider agrees not to bill a Member for medically necessary services covered by Vaya so long as the Member is eligible for coverage.
C. Liability: The Provider understands and agrees that the NCDHHS does not assume liability for the actions of, or judgments rendered against, Vaya, its employees, agents, or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NCDHHS for any duty owed to the Provider by Vaya or any judgment rendered against Vaya.
D. Non-discrimination Equitable Treatment of Members: The Provider agrees to render Provider Services to Members with the same degree of care and skills as customarily provided to the Provider's patients who are not Members, according to generally accepted standards of medical practice. The Provider and Vaya agree that Members and non-members should be treated equitably. The Provider agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
E. Department authority related to the Medicaid program: The Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 CFR §431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.
F. Access to provider records: The Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Contract(s) between Vaya and the Provider and any records, books, documents, and papers that relate to the Contract(s) between Vaya and the Provider and/or the Provider's performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NCDHHS deems necessary for contract enforcement or to perform its regulatory functions:
    I. The United States Department of Health and Human Services or its designee;
    II. The Comptroller General of the United States or its designee;
    III. The North Carolina Department of Health and Human Services (NCDHHS), its Medicaid Managed Care program personnel, or its designee
    IV. The Office of Inspector General

V. North Carolina Department of Justice Medicaid Investigations Division
VI. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NCDHHS;
VII. The North Carolina Office of State Auditor, or its designee;
VIII. A state or federal law enforcement agency and
IX. Any other state or federal entity identified by NCDHHS, or any other entity engaged by NCDHHS.

G. The Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the NC Department of Health and Human Services. Nothing in this section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.
H. N.C.G.S. §58-3-225, Prompt claim payments under health benefit plans: The Provider shall submit all claims to Vaya or its Subcontractors for processing and payments within three-hundred-sixty-five (365) calendar days for the Tailored Plan and Medicaid Direct PIHP from the date of covered service or discharge (whichever is later). However, the Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.
    I. For Medical claims (including BH):
        a. Vaya shall within eighteen (18) calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
        b. Vaya shall pay or deny a clean medical claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
        c. Vaya shall pay or deny a medical pended claim within thirty (30) calendar days of receipt of the requested additional information.
    II. For Pharmacy Claims:
        a. Vaya shall within fourteen (14) calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.

b. Vaya shall pay or deny a pharmacy pended claim within fourteen (14) calendar days of receipt of the requested additional information.

III. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, Vaya shall deny the claim per N.C.G.S. §58-3-225 (d).

a. Vaya shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

IV. If Vaya fails to pay a clean claim in full pursuant to this provision, Vaya shall pay the Provider interest and liquidated damages. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

V. Vaya shall pay the interest as provided in Section I.25.H.(IV) and shall not require the Provider to request the interest.

I. Contract Effective Date: The contract shall at a minimum include the following in relation to the effective date of the contract: The effective date of any provider added under this contract shall be the later of the effective date of this contract or the date of the provider's enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider Enrollment system(s).

J. Tobacco-free policy per the applicable NCDHHS Contract requirements.

26. During contract negotiations with an Applicant or Network Provider, Vaya will, in its discretion, make changes to any provision that is not required by the applicable NCDHHS Contract, so long as the change does not conflict with any requirements in the NCDHHS Contract or state or federal law, or materially conflict with Vaya's business operations applicable to Network Providers.

27. Advanced Medical Home contracting

A. Most primary care practices serving Medicaid beneficiaries are participating in the Advanced Medical Home (AMH) program in Tiers 1-3.

B. Vaya will pay AMH practices serving as the PCP for Members the Medical Home Fee as required by the applicable NCDHHS Contract.

C. AMH practices must become certified as AMH+ practices to provide Care Management to Members under the Tailored Plan or Medicaid Direct PIHP.

D. Vaya will incorporate all Department-defined AMH practice standards into our contracts with AMH practices. Vaya may negotiate additional terms as mutually agreed upon by the AMH practice and Vaya. If NCDHHS provides any new guidance, policy, operational manual, or program-specific requirements Vaya will incorporate them into the contractual requirements for the AMH practice.

Section II: Out-of-Network (OON) Reimbursement

1. In accordance with 42 CFR §438.206(b)(5), Vaya shall coordinate payment with the OON Provider to ensure that the cost to the Member is no greater than it would be if services were provided by a Network Provider.
2. Except for Emergency Services, Post-Stabilization Care Services, services provided during transitions in coverage, or for services that are readily available from a network provider (e.g., durable medical equipment), Vaya and its Subcontractors shall not reimburse an OON Provider more than ninety (90%) of the Medicaid Fee-for-Service rate if Vaya has made a Good Faith Effort to negotiate and execute a Network Contract with the provider, but the provider has refused that contract.
    A. If Vaya or its Subcontractor does not make a Good Faith Effort to contract with the OON Provider in accordance with this policy, Vaya and its Subcontractor shall reimburse an OON Provider at one hundred percent (100%) of the Medicaid Fee-for-Service rate unless Vaya has exercised its authority to maintain a Closed Network for Closed Network Services as set forth in N.C.G.S. §108D, Article 3.
    B. Exceptions to this requirement may be approved by the Chief Financial Officer, or their specifically authorized designee.
3. In accordance with SSA 1932(b)(2)(D), Vaya shall pay OON Providers who provide Emergency Services or Post-Stabilization Care Services to a Member no more than the applicable Medicaid Fee for Service rates. Vaya shall reimburse out-of-State hospitals that are also OON for Emergency Services and Post-Stabilization Care Services according to the applicable Medicaid Fee for Service rates. In accordance with 42 CFR §422.113(c), Vaya shall reimburse for OON Post-Stabilization Care Services that are pre-approved by Vaya.
4. Vaya shall reimburse out-of-state OON Providers for medically necessary services according to the Medicaid Fee for Service rates specified in SPAs 4.19-A and 4.19-B (Medicaid) when the services meet any of the following criteria:
    A. Are more reasonably available than can be provided by an in-State Network Provider; or
    B. The care and services are provided in any one of the following situations:
        I. In response to an Emergency Medical Condition;
        II. The health of the Member would be endangered if the care and services were postponed until the Member returns to North Carolina; or
        III. The health of the Member would be endangered if travel were undertaken to return to the State.

Section III: Contract Initiation and Development

1. In the case of Closed Network Services, contract initiation and development for contracting

with any Closed Network Applicant or renewing a Network Contract with any Closed Network Provider shall be conducted in accordance with Policy 2831 Selection and Retention of Providers .

2. In the case of non-Closed Network Services, contract initiation and development for contracting with any Open Network Applicant or renewing a Network Contract with any Open Network Provider shall be conducted in accordance with Policy 2730 Plan Beneficiary Enrollment and Disenrollment.
3. In the case of sub-contracted Subcontractor Services, contract initiation and development for contracting with any Open Network Applicant or renewing a Network Contract with any Open Network Provider shall be conducted in accordance with Subcontractor's applicable policies and the terms and conditions of the Subcontractor Contract.
4. Within three (3) business days following approval for contracting as outlined in Policy 2730 Plan Beneficiary Enrollment and Disenrollment, the Provider Enrollment Team or assigned Provider Network Contract Manager will initiate a request for a new Network Contract in the designated contracting platform.
5. Vaya will accurately and timely load all required information into the claims adjudication and payment system for new provider contracts, provider demographic information, changes in provider terms, changes in provider demographic information, updated prior authorization requirements and changes to the Provider Directory.
6. Upon execution of a contract, the Provider Enrollment Team, through a manual or automated process, or a combination thereof, will be responsible for loading providers in the claims payment system within the following time frames to ensure timely payment or denial for a health care service, supply, or item already provided to a Member in the Medicaid Direct PIHP or Tailored Plan:
    A. New enrolled provider: Within ten (10) business days after receipt of a completed contract.
    B. New enrolled hospital or facility provider: Within fifteen (15) business days upon execution of a contract.
    C. New enrolled provider joining an existing contract: Within five (5) business days upon execution of a completed contract.
    D. Changes for a re-enrolled provider, hospital or facility joining an existing contract: Within five (5) days upon receipt of the Provider Enrollment File from NC Medicaid.
    E. Changes to existing contract terms: Within thirty (30) calendar days of the effective date after the change is received on the Provider Enrollment File from NC Medicaid.
    F. Changes to a provider's service location or demographic data or other information related to a Member's access to services: Updated no later than thirty (30) calendar days after receipt of the Provider Enrollment File.

7. Any PNO employee, after obtaining approval from PNO leadership, may submit a request for an amendment or addendum to any existing Network Contract by initiating a request in the Platform. Other departments who wish to amend a Network Contract, add a new SOW, or make other changes impacting a Network Contract, must route such request through PNO. The Contracts Team will only process requests for new or amended Network Contracts from a member of the Executive Leadership Team (ELT) or their authorized designee, the PNO departments, or the Legal Team.
8. For Medicaid Direct PIHP (through 6/30/24) and Tailored Plan (Beginning 7/1/24) Only – Development of non-Medicaid funding allocations:
    A. Allocation of Non-Medicaid funding is determined by the Network and Services Management Committee (NSMC) prior to the beginning of each State Fiscal Year (SFY). Allocations may be changed or amended at any point during the SFY by the NSMC.
    B. If non-Medicaid funds are recommended for allocation to a provider not currently in the Vaya Closed Network, the request for enrollment process should be followed.
    C. If non-Medicaid funds are recommended for allocation to a Network Provider who does not have an existing non-Medicaid contract OR a Network Provider seeks to add additional sites or services to a non-Medicaid contract, the Network Provider must complete and submit Vaya's provider contract request form available on the provider-facing Vaya Health website.
    D. If changes are made to any existing non-Medicaid funding allocation, a contract amendment is required, and PNO must submit a request as outlined in Section III. All funding changes must be approved by PNO and Finance leadership and/or by the NSMC following review by the Rate Setting Committee.
9. For Medicaid Direct PIHP (through 6/30/24) and Tailored Plan (Beginning 7/1/24) Only – Development of Network Contracts utilizing non-Medicaid TBI funding:
    A. TBI purchases of $500.00 or less may be made with a Vaya credit card in accordance with Policy 2386 Out of Network Authorizations and Contracting.
    B. TBI purchases between $501.00 and $4,999.99, the requestor must comply with Policy 2386 Out of Network Authorizations and Contracting.
    C. For TBI purchases of $5,000.00 or more, depending on the purchase, the requestor must comply with Policy 2386 Out of Network Authorizations and Contracting.
10. Any PNO or Provider Enrollment Team staff requesting a new or amended Network Contract must initiate a request in the Platform ("Request").
11. The complete Request must be submitted by the earlier of any of the following:
    A. At least ten (10) business days prior to the requested start date of the new or amended Network Contract, or

B. Within three (3) business days following Vaya's determination that a new or amended Network Contract is required because of a request for change, unless:
    I. There is a demonstrated health, safety, or compliance risk to Vaya or to a Member that would be mitigated by the earlier execution of such Network Contract; or
    II. The CEO, CFO, General Counsel, or their designee(s) approve a different timeframe.

12. The next step in the Platform workflow is for the Contracts Team to review the Request for completeness and accuracy, ensuring that the request incorporates and/or attaches all information and details necessary to process an accurate Network Contract, including but not limited to the following:
    A. The provider's correct federal tax identification number;
    B. The provider's correct, full legal name, without abbreviations or shorthand as identified on the provider enrollment file and the NC Secretary of State;
    C. The category of services to be delivered under the Network Contract by the provider;
    D. The provider's official mailing address and the email address that should be used for electronic signature routing; and
    E. The applicable funding source (e.g., fee-for-service, Medicaid-only, Medicaid and State funded, etc.).
    F. The applicable type of contract (e.g., ancillary, community-based services, hospital, primary care, specialty care, Essential Provider, pregnancy management, behavioral health)
    G. The applicable tailored care management designation, if applicable
    H. The advanced medical home tier, if applicable
    I. The reimbursement rate and payment methodology for each category of service, tailored care management designation, advanced medical home tiers, and/or value based contracting measures at a site-specific level covered by the Network Contract;
    J. The provider's health plan status with the NC Medicaid;
    K. Any attachments specific to the provider (e.g., value based contracting provisions, service category addendum, Finance attachments, Scope(s) of Work, etc.). The attachment must identify designated amounts, allocations, and payment requirements to be incorporated into the Network Contract.
        I. Finance department staff are responsible for verifying that the financial attachment is supported by allocations in the service budget developed by the NSMC.
        II. PNO department staff are responsible for verifying that the financial attachment and scope of work match.

13. Within three (3) business days of completion of PNO's Request within the Platform, the Contracts Team is responsible for approving the internal Request or reaching out to the requestor for missing information. The requestor must then submit any missing information necessary to generate a Network Contract by updating the request in the Platform. The three (3) business day timeframe for the Contracts Team to approve the request is restarted effective the date the Request in the Platform is updated with complete information.
14. If the request is complete, the Contracts Team will proceed with the preparation, negotiation, and execution of a Network Contract.
15. The Contracts Team creates a Network Contract, amendment, or extension utilizing the applicable contract template(s) as outlined in Section III, incorporating all necessary attachments and appendices, and the Network Contract is electronically routed for signature in the following order:
    A. Provider;
    B. CFO or designee (Executive Director of Finance) for pre-audit review;
    C. CEO or designee.
16. The Contracts Team will track progress while the Network Contract is in the electronic signature loop.
17. If the provider seeks to negotiate terms and conditions of the Network Contract or amendment, the General Counsel, Deputy General Counsel, or designee will be consulted. No changes to a Network Contract or amendment template shall be made without express permission of the CEO, General Counsel, Deputy General Counsel, or designee.
18. Upon completion of the electronic signature process:
    A. The Contracts Team causes the fully executed Network Contract to automatically route to the Network Provider;
    B. The Platform will notify the requestor of the Network Contract when the Network Contract has become fully executed;
    C. The requestor will coordinate with the Provider Enrollment Team to ensure that the Provider Enrollment Team has the information necessary to update the claims system as needed;
    D. The PNO departments shall have access to the Platform to keep track of the Network Contract status;
    E. The Platform will automatically store and be available to report on or track the status of the Network Contract in the Platform;
    F. The executed Network Contracts and associated metadata will be extracted from the Platform, through a semi-automated process using a crush SFTP file format, and loaded into the Vaya Employee Resource Network, where relevant staff will be provided access to the Network Contract.

G. The Contracts Team will verify that the Platform and the Vaya Employee Resource Network are updated with the correct documentation and metadata.
H. PNO must notify Vaya senior leadership, or other impacted staff, of any newly contracted Network Providers, or changes to existing Network Contracts, as necessary.

Section IV: Contract Templates and Minimum Requirements

1. The Contracts Team will utilize a master Network Provider Agreement template developed by the Legal Team and approved by NCDHHS. The Legal Department will make all changes requested by NCDHHS as a condition of approval, whether the template has been utilized in contracting with a Network Provider. Vaya will discontinue use of previously submitted contract templates once an amended version is approved by NCDHHS.
2. If a new contract template is developed, Vaya will submit the new template to NCDHHS for approval at least sixty (60) days before use with a Network Provider.
3. The Legal Team reviews templates no less than annually.
4. Templates will be designed to address each of the following provider types at minimum:
    A. Licensed Independent Practitioner (LIP);
    B. Agency/Facility; and
    C. Hospital and/or Health System.
5. All Network Contracts will contain the following elements at minimum:
    A. Full legal name of all individuals or entities that are a party to the contract [N-NM 9(a)];
    B. Correct and complete address where notices are to be sent (generally, the administrative headquarters);
    C. The following or substantially similar Pre-Audit statement: This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. §159-28.
    D. Name and signatures of:
        I. Vaya CFO or designee;
        II. Authorized signatory for the provider, usually the CEO;
        III. Vaya CEO, or a designee;
    E. Conditions for participation as a Participating Provider [N-NM 9(b)];
    F. Obligations and responsibilities of Vaya and the Participating Provider, including any obligations for the Participating Provider to participate in Vaya's management, grievance, complaint and/or other programs [N-NM 9(c)];
    G. Requirement that all Participating Primary Care Providers perform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings for Members less than twenty-one (21) years of age;

H. Requirement that the Participating Provider notify Vaya with a Member in a high acuity clinical setting is being discharged;
I. Events that may result in the reduction, suspension, or termination of network participation privileges [N-NM 9(d)];
J. The specific circumstances under which Vaya may require access to Members' medical records as part of Vaya's programs or health benefits [N-NM 9 (e)];
K. Health care goods and/or services to be provided and any related restrictions [N-NM 9(f)];
L. Requirements for claims submission and any restrictions on billing of Members [N-NM 9(g)];
M. Federal aid category when federal funds will be utilized to reimburse the Participating Provider. Participating Provider payment methodology and fees [N-NM 9(h)];
N. Mechanisms for dispute resolution by Participating Providers [N-NM 9(i)];
O. Term of contract and procedures for terminating the contract [N-NM 9(j)];
P. Requirements with respect to preserving the confidentiality of protected health information [N-NM 9(k)];
Q. Prohibitions regarding discrimination against Members [N-NM 9(l)];
R. Requirement that the Participating Provider comply with all applicable federal and state laws, rules, regulations, and payor program requirements, including but not limited to the Vaya Provider Operations Manual;
S. All mandatory provisions required to be included by the applicable NCDHHS Contract, including but limited to, the provisions set forth in Section II., Paragraph 24A.-H. and Paragraph 25A.-H above;
T. The NCDHHS IHCP Addendum template for IHCPs in the form and format required by NCDHHS per the applicable NCDHHS Contract; and
U. To the extent applicable and accepted by the contracting party, confidentiality, insurance, indemnification, limitation of liability, governing law, governmental immunity, and/or exculpatory terms that have been reviewed and approved by the General Counsel, Deputy General Counsel, or one of their designees.

6. The Network Contract shall not include:
   A. Any clauses or language that could restrict Participating Providers from discussing matters relevant to Members' health care [N-NM 8(a)]
   B. Any clause or language that prohibits or restricts a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:
      I. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

II. Any information the Member needs to decide among all relevant treatment options.
III. The risks, benefits, and consequences of treatment or non-treatment.
IV. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

C. A definition of "medical necessity" that emphasizes cost or resource issues above clinical effectiveness [N-NM 8(b)]
D. Any exclusivity or non-compete provisions in contracts with providers (including non-medical services providers) or otherwise prohibit a provider from providing services for or contracting with any of Vaya's health plans or any other PHP
E. Any provisions prohibited by N.C.G.S. §58-50-295.

7. In addition to the Network Contract, the Contracts Team shall assemble all other applicable attachments, appendices or other documents requiring signature, which may include but are not limited to:
   A. Scope(s) of Work;
   B. Vaya Value Based performance metrics;
   C. Compensation Schedule;
   D. Specific Provider Type Attachments (e.g., advanced medical homes, care management agencies, IHCPs, value-based program participants, MH/SUD/IDD/TBI Services providers, non-Medicaid non-Fee-for-Service providers, primary care and specialty care physical health providers, local health departments, pregnancy management programs, and laboratories providers)
   E. Finance Attachments;
   F. Federally Required Certifications;
   G. Electronic Funds Transfer (EFT) Form;
   H. Access agreements for Vaya software platforms;
   I. Trading Partner Agreement (TPA);
   J. IRS Form W-9;

Section V: Contract Renewals

1. NSMC is responsible for making recommendations about whether to renew Medicaid Network Contracts in accordance with Policy 2831 Selection and Retention of Providers and the Network Access Plan. The ELT is responsible for reviewing and either approving, amending, or rejecting NSMC recommendations.
2. The NSMC makes decisions about renewals of non-Medicaid funded Network Contracts based on available federal, state, county, and grant funding allocations and applicable provisions of Policy 2831 Selection and Retention of Providers .

3. The ELT, or its designee, must notify the Contracts Team of non-renewals for Network Contracts at least thirty (30) days prior to the termination date of any Network Contract. Failure to meet this deadline may result in issuance of contract extensions or non-payment of claims. Vaya shall not pay any claims for services delivered after the termination date of any Network Contracts, unless reimbursement is approved by the CEO or CFO or respective designee, a valid extension has been executed by Vaya and the Network Provider, or in accordance with the requirements of 42 CFR §438.114(c)(i).
4. The PNO departments are responsible for preparing comprehensive lists identifying the Network Providers selected for renewal and the applicable contract type (e.g., non-Medicaid/ Medicaid, length of term, specific attachments/appendices) for the Contracts Team to generate the contracts. Any changes to the Network Contract terms or conditions (i.e., sites, services, or funding allocation) require PNO to initiate a request in the Platform through the procedure described above.
5. The Contracts Team shall generate notifications of non-renewal using a template approved by the General Counsel or designee, and the notification must be delivered to the Network Provider at least thirty (30) days prior to the termination date of the Network Contract.
6. The Contracts Team shall generate the renewal contracts using templates approved by the General Counsel or designee and by NCDHHS and follow the steps herein.
7. In the case of Subcontractors, the renewal of Network Contracts shall be conducted in Good Faith and in accordance with the Subcontractor's applicable policies and the terms and conditions of the Subcontractor Contract.

Section V: Provider Contracting Disputes

1. Vaya shall give written notice to any Applicant with whom it declines to contract within five (5) business days after Vaya makes its final decision. The notice shall include the reason for Vaya's decision, the Provider's right to appeal that decision, and how to request an appeal.
2. Network Provider dispute resolution shall be conducted in compliance with Vaya's applicable policies, including, but not limited to, Policy 2610 Provider Grievances and Dispute Resolution, the Provider Operations Manual, and the Network Contract.
3. In the case of Subcontractors, Open Network Provider dispute resolution shall be conducted in compliance with respective Subcontractor's applicable policies, the terms and conditions of their contract with Vaya, and the terms and conditions of their contract with the provider.

Related Documents (All Hyperlinked)
Document Library: Vaya Health Provider Contract Request Form

PT Documents: Provider Credentialing, Re-credentialing, and Enrollment; Out of Network Authorizations and Contracting; Selection and Retention of Providers Plan Beneficiary Enrollment and Disenrollment; Provider Grievances and Dispute Resolution **Other:**

Oversight References **Contracts:** BH/IDD Tailored Plan, Medicaid Direct PIHP **Statutory/ Regulatory Citations:** 42 CFR §438.214; N.C.G.S. §108D-1(3); Section 1115 of the Social Security Act; Article 4 of Chapter 108D of the North Carolina General Statutes; G.S. 108D-22(b); 42 CFR §438.2; N.C.G.S. §108D-22-26; N.C.G.S. §108D, Article 3; 42 CFR Part 455 Subpart B and E; N.C.G.S. §122C-3(20c); 42 CFR §438.806(a); 42 CFR Part 438; N.C.G.S. §108D-1(27); N.C.G.S. §108D-1(30); N.C.G.S. 58-93-5; N.C.G.S. §108D-1(36); 42 CFR §438.114(c)(i); Local Government Budget and Fiscal Control Act, N.C.G.S. Chapter 159, Article 3; 42 CFR §438.14(a); N.C.G.S. §108D, Article 3; N.C.G.S. §143-48; Executive Order 150 (1999); N.C.G.S. §143-128.4; N.C.G.S. §58-51-37(c)(2); 42 CFR §431.10; N.C.G.S. §58-3-225; 42 CFR §438.114(c)(i) **NCQA:** Subcategories of NCQA not selected.
Supersedes: v.6 Good Faith Provider Contracting