PROVIDER OPERATIONS MANUAL

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

Effective March 5, 2026

VAYAHEALTH

INTRODUCTION

Welcome to 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 you are listed in the Vaya Provider Directory and are eligible for referrals from Vaya. This does not include providers delivering care to Vaya members under an Out-of-Network (OON) Agreement.

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 your employees and contractors are familiar with the requirements.

Throughout this manual, the term "member" generally refers to Medicaid beneficiaries and recipients of State-funded services who are served by Vaya, unless otherwise noted. If unspecified, the information in this manual applies to all Vaya network providers and practitioners, regardless of funding source. Some information also applies to providers enrolled with Vaya as an OON provider. 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., Eastern time, 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 North Carolina Department of Health and Human Services (NCDHHS or the Department), Vaya will make this 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. 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.

Key Vaya Health Contacts

Provider Support	Phone:	Provider Support Service Line: 1-866-990-9712 *7 a.m.-6 p.m., Monday-Saturday, including holidays*
	Email:	provider.info@vayahealth.com
Provider Portal	Online:	providers.vayahealth.com/provider-portal
Provider Central Website	Online:	providers.vayahealth.com
	Forms:	providers.vayahealth.com/resources/forms
	Bulletins:	providers.vayahealth.com/bulletins
IT ServiceDesk	Online:	Provider ServiceDesk Request Form
	Phone:	1-800-893-6246, ext. 1500
	Email:	ServiceDesk@vayahealth.com
Claims and Payments	Online:	Provider ServiceDesk Request Form
	Phone:	1-800-893-6246, ext. 2455 (behavioral health) 1-800-893-6246, ext. 2456 (physical health)
Authorizations and Notifications	Email:	UM@vayahealth.com
	Phone:	1-800-893-6246, ext. 1515 (behavioral health) 1-800-893-6246, ext. 1526 (physical health)
Provider Enrollment Services	Phone:	1-855-432-9139
	Email:	ProviderEnrollment@vayahealth.com
Primary Care Provider Enrollment	Email:	PCPEnrollment@vayahealth.com
Member Eligibility and Enrollment	Phone:	1-800-893-6246, ext. 2355
	Email:	EandE@vayahealth.com
Incident Reporting	Email:	IncidentReport@vayahealth.com
	Fax:	828-398-4407
Provider Appeals	Email:	claims.appeals@vayahealth.com (appeals of claims denials)
	Email:	provider.appeals@vayahealth.com (all other appeal types)
Grievances and Complaints:	Phone:	1-800-893-6246, ext. 1600
	Email:	ResolutionTeam@vayahealth.com
Member Appeals	Phone:	1-800-893-6246, ext. 1400
	Email:	member.appeals@vayahealth.com
	Fax:	1-833-845-5616
Fraud, Waste, and Abuse Reporting	Phone:	24/7 Compliance Hotline: 1-866-916-4255
	Email:	LegalandCompliance@vayahealth.com
	Online:	EthicsPoint
Records Management	Email:	health.information@vayahealth.com
Legal Inquiries	Email:	LegalandCompliance@vayahealth.com
	Fax:	828-252-9584

Member Service Lines

Member and Recipient Service Line	Phone: Email:	1-800-962-9003 *7 a.m.-6 p.m., Monday-Saturday, including holidays* member.services@vayahealth.com
Behavioral Health Crisis Line	Phone:	1-800-849-6127, available 24/7
Pharmacy Service Line	Phone:	1-800-540-6083 *7 a.m.-6 p.m., Monday-Saturday, including holidays*
Nurse Line (operated by Wellcare)	Phone:	1-800-290-1623, available 24/7

General Information

Business Calls	Phone:	1-800-893-6246 *8:30 a.m.-5 p.m., Monday-Friday*
Main Fax	Fax:	828-412-4098
Administrative Offices	U.S. Mail:	200 Ridgefield Court, Suite 218, Asheville, NC 28806

Vendor Contacts

Pharmacy Services (Navitus Health Solutions)	Phone: Online: Fax: U.S. Mail:	Pharmacy Service Line: 1-800-540-6083 *7 a.m.-6 p.m., Monday-Saturday, including holidays* Pharmacy Portal: prescriber.orbisrx.com 1-855-668-8553 1025 West Navitus Drive, Appleton, WI 54913
Vision Services (Avēsis)	Online:	Portal: myavesis.com
Specialty Physical Health Services (EviCore Healthcare)	Phone: Online:	1-800-918-8924 Portal: evicore.com/provider *Radiology, cardiology, Durable Medical Equipment, and occupational, physical, and speech therapy*
Non-Emergency Medical Transportation (Modivcare)	Phone: Online:	Facility Line: 1-855-397-3606 *7 a.m.-6 p.m., Monday-Saturday (to help members schedule, change, or cancel a ride)* Portal: tripcare.modivcare.com/login

Message from the Area Director/CEO

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. It covers the Vaya Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan for Medicaid members, which we call Vaya Total Care, as well as services provided through our NC Medicaid Direct Prepaid Inpatient Health Plan (PIHP) and State-funded services.

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 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 NCDHHS. 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.

Vaya exists to benefit the lives of people with behavioral health, I/DD, and TBI needs and connect them with the services and supports they need to live their best lives—a mission that requires providers to deliver care. 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

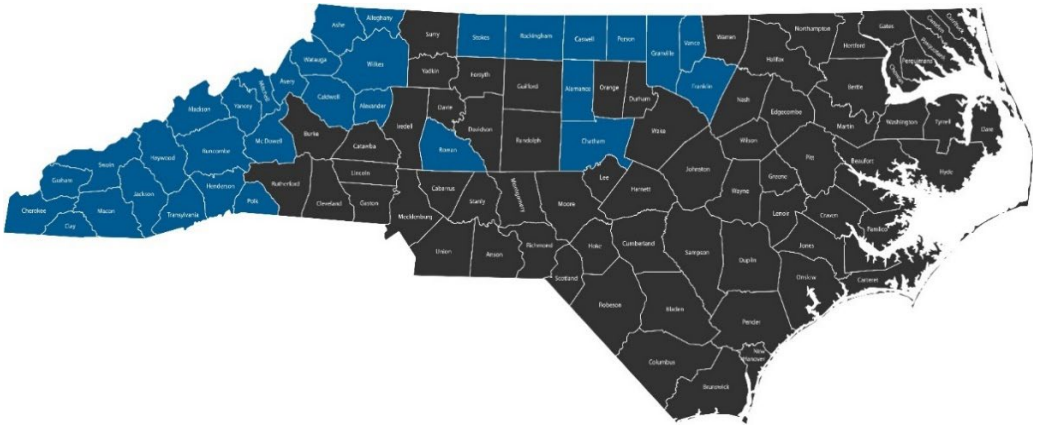
Table of Contents

Who We Are

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. Vaya is a Local Management Entity/Managed Care Organization (LME/MCO) and is responsible for the management and oversight of the public system of services for people with serious mental illness, severe and persistent mental illness, severe substance use disorder, intellectual/developmental disability (I/DD), and traumatic brain injury (TBI) at the community level. Vaya previously 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.

Vaya achieved full Health Plan Accreditation status from the National Committee for Quality Assurance (NCQA) on Dec. 1, 2025. Vaya's administrative headquarters are in Asheville (Buncombe County), with additional office locations throughout the region, including co-locations with hospital systems. All Vaya offices and staff can be reached by calling 1-800-893-6246 (toll-free). Addresses and local phone numbers for additional offices on our website.

Vaya Health Region



Governance and Advisory Boards

Vaya is governed by a Board of Directors, appointed in accordance with N.C.G.S. § 122C, that provides broad organizational oversight and policy direction and ensures we remain accountable to community needs and local government. It includes representatives from each of our four Regional Boards, which consist of individuals appointed by each Board of County Commissioners in our region and serve in an advisory capacity. The Board of Directors also includes representatives from the Vaya Consumer and Family Advisory Committee, the president of the Provider Advisory Council (in a non-voting *ex officio* capacity), an appointee of the North Carolina Department of Health and Human Services (NCDHHS) Secretary, and at-large members chosen for their professional experience, expertise, qualifications, or attributes in health care, social services, social determinants of health, finance, insurance, local government, law enforcement, or other related fields.

The **Provider Advisory Council (PAC)** advises Vaya on issues affecting network providers. Membership reflects a broad cross-section of provider types, services, and disability groups served. The PAC is a self-governing committee, and the PAC president serves on the Board of Directors in a non-voting *ex officio* capacity. All network providers are required to comply with the PAC's Code of Ethics, available on our Provider Advisory Council webpage, as a condition of network participation.

Additional advisory boards include:

- **Consumer and Family Advisory Committee (CFAC):** A self-governing committee, the CFAC comprises Vaya members, and their families, and helps ensure the involvement of Vaya members/families in our oversight, planning, and operational committees. Four CFAC members serve as voting members of the Board of Directors. Learn more on our Consumer and Family Advisory Committee webpage or email CFAC@vayahealth.com.
- **Long-Term Services and Supports (LTSS) Member Advisory Committee:** LTSS Member Advisory Committee members garner stakeholder input and advice regarding LTSS. Membership reflects the LTSS populations Vaya serves.
- **Human Rights Committee (HRC):** The HRC consists of a majority of people who receive services and their family members. The HRC monitors Vaya's compliance with laws, rules, and regulations regarding member rights and confidentiality and reviews any concerning trends.
- **NC Innovations Stakeholders Committee:** Our Innovations Stakeholders meetings focus on topics related to the NC Innovations Waiver and provide an outlet to receive participant feedback.

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, I/DD, and/or TBI, including the medical, behavioral, and non-medical drivers of their health. We exist to benefit the lives of people with mental health, substance use disorder, I/DD, and 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 network providers and 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 health care 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, families, providers, and other stakeholders to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better.

Provider Portal

Vaya's Provider Portal, accessible at providers.vayahealth.com/provider-portal, allows users to submit claims, view and manage all claims (including claims submitted outside the portal, such as Electronic Data Interchange [EDI] claims), view claim payment information, submit service authorization requests (SARs), view and manage authorizations, submit recipient enrollment requests, and more. In addition, providers may 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 portal. The portal is the primary mechanism for sharing data with providers, including administrative, clinical, and claims/encounter data and information about quality and cost measurements.

To access provider portals for Vaya's delegated subcontractors, visit our Provider Portal webpage.

Provider Communication and Resources

Vaya maintains a dedicated website for providers, Provider Central, accessible at providers.vayahealth.com. Provider Central includes helpful information on network participation, service authorization, and billing, as well as forms, provider resources, trainings, and job aids.

Vaya shares critical information, including changes in policy or requirements that impact network providers, through our official Vaya Provider Communication Bulletin. The bulletin is delivered 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.**

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

- NC Medicaid Bulletins
- DMHDDSUS Communication Bulletins

Vaya also offers regular Provider Touchpoint webinars and provides technical assistance related to requirements of the Vaya provider agreement, this manual, NCDHHS, and other oversight authorities. Technical assistance topics may include authorization processes, claims, billing and reimbursement, development of appropriate clinical services, and quality improvement initiatives. Additionally, we can 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.

SECTION 1

Benefit Plans and Covered Services

Benefit Plans

Vaya contracts with NCDHHS to manage the following benefit plans for Medicaid and State-funded services in our region:

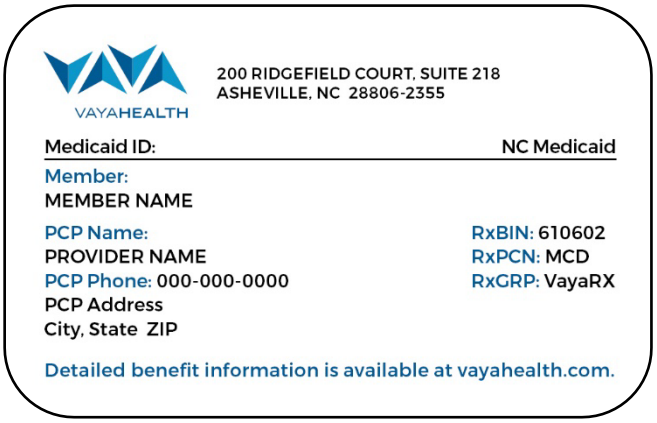
Health Plan	Benefit Package
NC Medicaid Managed Care Behavioral Health and I/DD Tailored Plan (Tailored Plan)	***Medicaid benefit package (Vaya Total Care):*** Physical health, pharmacy, behavioral health, I/DD, and TBI services, plus LTSS and Non-Emergency Medical Transportation (NEMT)*
	State-funded services: Non-Medicaid behavioral health, I/DD, and TBI services for uninsured/underinsured people who cannot afford care
NC Medicaid Direct Prepaid Inpatient Health Plan (PIHP)	Behavioral health, I/DD, and TBI services for beneficiaries otherwise served by NC Medicaid Direct*

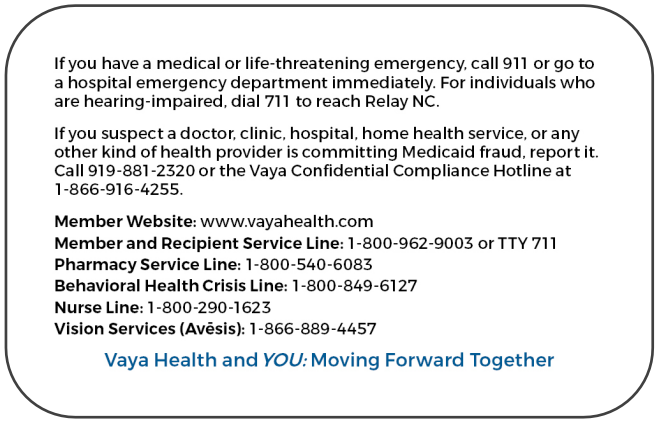
**Vaya also manages the NC Innovations Waiver, a 1915(c) Medicaid Home and Community-Based Services (HCBS) waiver, for eligible Tailored Plan and NC Medicaid Direct members with I/DD in our region.*

Additionally, Vaya processes authorization requests, performs utilization review, and pays claims for Medicaid Direct PIHP services delivered to Eastern Band of Cherokee Indians (EBCI) Tribal Option members. The EBCI Tribal Option Care Manager is the primary Care Manager and coordinates services with the member and service provider(s). The EBCI Tribal Option has authority to refer its members to Medicaid Direct PIHP services delivered by Vaya network providers.

Vaya Total Care Medicaid ID Card

Vaya Total Care members receive a Medicaid ID Card issued by Vaya as seen in the sample below. For more information, visit ncmedicaidplans.gov.





NC Medicaid Direct members receive a Medicaid ID Card issued by NC Medicaid. State-funded services recipients do not receive an ID card.

Medicaid Covered Services and Clinical Coverage Policies

Vaya manages the following covered Medicaid services for Vaya Total Care members. For NC Medicaid Direct members, Vaya manages only the behavioral health, I/DD, and TBI services listed below.

Covered services listed are no less in amount, duration and scope of such services in the NC Medicaid State Plan fee-for-service program. For details, see the NC Medicaid Program Specific Clinical Coverage Policies webpage. NCDHHS reserves the right to update the clinical coverage policies (CCPs) for covered benefits.

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations

SERVICE	KEY REFERENCES
Allergies	• NC Medicaid Clinical Coverage Policies: 1N-1, Allergy Testing; 1N-2, Allergy Immunotherapy
Ambulance services	• 42 CFR § 410.40 • NC Medicaid State Plan Att. 3.1- A.1, Page 18 • NC Medicaid Clinical Coverage Policy 15, Ambulance Services
Anesthesia	• NC Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; • NC Medicaid Clinical Coverage Policies 1L-1, Anesthesia Services; 1L-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Auditory implant external parts	• NC Medicaid Clinical Coverage Policies 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair; 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn treatment and skin substitutes	• NC Medicaid Clinical Coverage Policies 1G-1, Burn Treatment; 1G-2, Skin Substitutes
Cardiac procedures	• NC Medicaid Clinical Coverage Policies 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs; 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Certified pediatric and family nurse practitioner services	• Social Security Act (SSA), Title XIX, Section 1905(a)(21) – 42 U.S.C. § 1396d(a)(21) • 42 CFR § 440.166 • NC Medicaid State Plan, Att. 3.1-A, Page 8a
Chiropractic services	• SSA, Title XIX, Section 1905(g) • 42 CFR § 440.60 • NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 • NC Medicaid Clinical Coverage Policy 1-F, Chiropractic Services
Clinic services	• SSA, Title XIX, Section 1905(a)(9) – 42 U.S.C. § 1396d(a)(9) • 42 CFR § 440.90 • NC Medicaid State Plan, Att. 3.1-A, Page 4 • NC Medicaid Clinical Coverage Policies 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments; 1D-3, Tuberculosis Control and Treatment Provided in Health Departments
Dietary evaluation and counseling and medical lactation services	• NC Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) • NC Medicaid Clinical Coverage Policy 1-I, Dietary Evaluation and Counseling and Medical Lactation Services

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
Durable medical equipment (DME)	• NC Medicaid State Plan, Att. 3.1-A, Page 3 • NC Medicaid Clinical Coverage Policies 5A-1, Physical Rehabilitation Equipment and Supplies; 5A-2, Respiratory Equipment and Supplies; 5A-3, Nursing Equipment and Supplies; 5B, Orthotics & Prosthetics
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services	• SSA, Title XIX, Section 1905(a)(4)(B) – 42 U.S.C. § 1396d(a)(4)(B) • NC Medicaid State Plan, Att. 3.1-A, Page 2
Family planning services	• SSA Title XIX, Section 1905(a)(4)(C) – 42 U.S.C. § 1396d(a)(4)(C) • NC Medicaid State Plan, Att. 3.1-A, Page 2 • NC Medicaid Clinical Coverage Policy 1E-7, Family Planning Services
Federally qualified health center (FQHC) services	• SSA, Title XIX, Section 1905(a)(2) (C) 42 U.C.S. § 1396d(a)(2)(C) • 42 CFR § 405.2411; 42 CFR § 405.2463; 42 CFR § 440.20 • NC Medicaid State Plan, Att. 3.1-A, Page 1 • NC Medicaid 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) • NC Medicaid State Plan Att. 3.1-A, Page 11
Gynecology	• NC Medicaid State Plan, Att. 3.1-B, Page 7(a) • NC Medicaid Clinical Coverage Policies 1E-1, Hysterectomy; 1E-2, Therapeutic and Non-therapeutic Abortions
Hearing aids	• NC Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 • NC Medicaid Clinical Coverage Policy 7, Hearing Aid Services
HIV case management services	• NC Medicaid Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management
Home health services	• SSA, Title XIX, Section 1905(a)(7) – 42 U.S.C. § 1396d(a)(7) • 42 CFR § 440.70 • NC Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A. l, Pages 13, 13a- 13a.4 • NC Medicaid Clinical Coverage Policy 3A, Home Health
Home infusion therapy	• NC Medicaid State Plan Att. 3.1-A.1, Page 13a.3 • NC Medicaid Clinical Coverage Policy 3H-1, Home Infusion Therapy
Hospice services	• SSA, Title XIX, Section 1905(a)(18) – 42 U.S.C. § 1396d(a)(18) • 42 CFR § 418 • NC Medicaid State Plan 3.1-A, Page 7 • NC Medicaid Clinical Coverage Policy 3D, Hospice Services

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services	• 42 CFR § 440.150 • NC Medicaid Clinical Coverage Policy 8E, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
Innovations Waiver services	• NC Medicaid Clinical Coverage Policy 8P, North Carolina Innovations
Inpatient hospital services	• SSA, Title XIX, Section 1905(a)(1) – 42 U.S.C. § 1396d(a)(1) • 42 CFR §440.10 • NC Medicaid State Plan, Att. 3.1-A, Page 1 • NC Medicaid State Plan, Att. 3.1-E • NC Medicaid Clinical Coverage Policies 2A-1, Acute Inpatient Hospital Services; 2A-2, Long Term Care Hospital Services; 2A-3, Out of State Services
Inpatient psychiatric services for individuals under age 21	• SSA, Title XIX, Section 1905(a)(16) – 42 U.S.C. § 1396d(a)(16) • 42 CFR § 440.160 • NC Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 • NC Medicaid Clinical Coverage Policy 8B, Inpatient Behavioral Health Services
Inpatient substance use services	• NC Medicaid Clinical Coverage Policy 8B, Inpatient Behavioral Health Services ○ Medically managed intensive inpatient withdrawal services ○ Medically managed intensive inpatient services
Inpatient and outpatient behavioral health services	• NC Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 • NC Medicaid Clinical Coverage Policies: ○ 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: – Mobile Crisis Management Diagnostic Assessment – Intensive-In-Home Services – Multisystemic Therapy – Child and Adolescent Day Treatment – Partial Hospitalization – Professional Treatment Services in a Facility Based Crisis Center – Medically Monitored Intensive Inpatient Services – Clinically Managed Residential Services ○ 8A-1: Assertive Community Treatment (ACT) Program; 8A-2, Facility- Based Crisis Management for Children and Adolescents; 8A-6, Community Support Team (CST); 8A-7, Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification); 8A-8, Ambulatory Withdrawal Management with Extended On-Site Monitoring; 8A-10, Clinically Managed Residential Withdrawal Services (social setting detoxification); 8A-11, Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification), 8A-5, Diagnostic Assessment; 8A-9, Opioid Treatment Program (OTP); 8A-12, Substance Abuse Intensive Outpatient Program (SAIOP); 8A-13, Substance Use Comprehensive Outpatient Treatment Program (SACOT); 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21; 8D-2, Residential Treatment Services;

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
	8D-4, Clinically Managed Population-Specific High Intensity Residential Program; 8D-5, Clinically Managed Residential Services (Substance abuse non-medical community residential treatment); 8D-6, Medically Monitored Intensive Inpatient Services; 8B, Inpatient Behavioral Health Services; 8C, Outpatient Behavioral Health Services Provided by Direct-enrolled Providers; 8F, Research-Based Behavioral Health Treatment for Autism Spectrum Disorders; 8G, Peer Supports; 8I, Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (behavioral health)
Laboratory and x-ray services	• 42 CFR § 410.32 • 42 CFR § 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 Medicaid Clinical Coverage Policies 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing; 1S-2, HIV Tropism Assay; 1S-3, Laboratory Service; 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring; 1S-9, Genetic Testing for Diagnosis and Treatment; 1S-10, Genetic Testing for Carrier and Prenatal; 1S-11, Genetic Testing - Gene Expression; 1S-12, Genetic Testing - Next Generation Sequencing (NGS); 1S-13, Cell and Gene Therapies; 1K-1, Breast Imaging Procedures; 1K-2, Bone Mass Measurement; 1K-6, Radiation Oncology • Vaya Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services
Maternal support services	• NC Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) • NC Medicaid Clinical Coverage Policies 1M-2, Childbirth Education; 1M-3, Health and Behavioral Intervention; 1M-4, Home Visit for Newborn Care and Assessment; 1M-5, Home Visit for Postnatal Assessment and Follow-up Care; 1M-6, Maternal Care Skilled Nurse Home Visit
Non-emergent transportation to medical care	• 42 CFR § 431.53 • 42 CFR § 440.170 • NC 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 U.S.C. § 1396d(a)(4)(A) • 42 CFR §440.40 • 42 CFR §440.140 • 42 CFR §440.155 • NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 • NC Medicaid Clinical Coverage Policies 2B-1, Nursing Facility Services; 2B-2, Geropsychiatric Units in Nursing Facilities
Obstetrics	• NC Medicaid State Plan, Att. 3.1-B, Page 7(a) • NC Medicaid Clinical Coverage Policies 1E-3, Sterilization Procedures; 1E-4, Fetal Surveillance; 1E-5, Obstetrics; 1E-6, Pregnancy Medical Home
Occupational therapy	• 42 CFR § 440.110 • NC Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 • NC Medicaid Clinical Coverage Policies 5A-1, Physical Rehabilitation Equipment and Supplies; 10A, Outpatient Specialized Therapies; 10B, Independent Practitioners (IP)

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
Office-based opioid treatment	• NC Medicaid Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine- Naloxone
Ophthalmological services	• NC Medicaid Clinical Coverage Policies 1T-1, General Ophthalmological Services; 1T-2, Special Ophthalmological Services
Optometry services	• SSA, Title XIX, Section 1905(a)(12) - 42 U.S.C. § 1396d(a)(12) • 42 CFR § 441.30 • NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a • N.C.G.S. § 108A-70.21(b)(2) • NC Medicaid 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) – 42 U.S.C. § 1396d(a)(13) • NC Medicaid State Plan, Att. 3.1-A, Page 5
Outpatient hospital services	• SSA, Title XIX, Section 1905(a)(2) – 42 U.S.C. § 1396d(a)(2) • 42 CFR §440.20 • NC Medicaid State Plan, Att. 3.1-A, Page 1
Personal care	• SSA, Title XIX, Section 1905(a) (24) – 42 U.S.C. § 1396d(a)(24) • 42 CFR § 440.167 • NC Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 • NC Medicaid Clinical Coverage Policy 3L, State Plan Personal Care Services
Pharmacy	• NC Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h • NC Medicaid Clinical Coverage Policies 9, Outpatient Pharmacy Program; 9A, Over-the-Counter-Products; 9B, Hemophilia Specialty Pharmacy Program; 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17; 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Physical therapy	• SSA, Title XIX, Section 1905(a)(11) – 42 U.S.C. § 1396d(a)(11) • 42 CFR § 440.110 • NC Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 • NC Medicaid Clinical Coverage Policies 5A, Durable Medical Equipment; 5A-1, Physical Rehabilitation Equipment and Supplies; 10A, Outpatient Specialized Therapies; 10B, Independent Practitioners (IP)
Physician services	• SSA, Title XIX, Section 1905(a)(5) – 42 U.S.C. § 1396d(a)(5) • 42 CFR §440.50 • NC Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A. l, Page 7h • NC Medicaid Clinical Coverage Policies 1A-2, Adult Preventive Medicine Annual Health Assessment; 1A-3, Noninvasive Pulse Oximetry; 1A-4, Cochlear and Auditory Brainstem Implants; 1A-5, Case Conference for Sexually Abused Children; 1A-6, Invasive Electrical Bone Growth Stimulation; 1A-7, Neonatal and Pediatric Critical and Intensive Care Services; 1A-8, Hyperbaric Oxygenation Therapy; 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair); 1A-11, Extracorporeal Shock Wave Lithotripsy; 1A-12, Breast Surgeries; 1A-13, Ocular Photodynamic Therapy; 1A-14, Surgery for Ambiguous Genitalia; 1A-15,

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
	Surgery for Clinically Severe or Morbid Obesity; 1A-16, Surgery of the Lingual Frenulum; 1A-17, Stereotactic Pallidotomy; 1A-19, Transcranial Doppler Studies; 1A-20, Sleep Studies and Polysomnography Services; 1A-21, Endovascular Repair of Aortic Aneurysm; 1A-22, Medically Necessary Circumcision; 1A-23, Physician Fluoride Varnish Services; 1A-24, Diabetes Outpatient Self-Management Education; 1A-25, Spinal Cord Stimulation; 1A-26, Deep Brain Stimulation; 1A- 27 Electrodiagnostic Studies; 1A-28, Visual Evoked Potential (VEP); 1A-30, Spinal Surgeries; 1A-31, Wireless Capsule Endoscopy; 1A-32, Tympanometry and Acoustic Reflex Testing; 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures; 1A-34, End Stage Renal Disease (ESRD) Services; 1A-36, Implantable Bone Conduction Hearing Aids (BAHA); 1A-38, Special Services: After Hours; 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions; 1A-40, Fecal Microbiota Transplantation; 1A-42, Balloon Ostial Dilation; 1B, Physician's Drug Program; 1-O-5, Rhinoplasty and/or Septorhinoplasty
Podiatry services	• SSA, Title XIX, Section 1905(a)(5) – 42 U.S.C. § 1396d(a)(5) • 42 CFR § 440.60 • N.C.G.S. § 90-202.2 • North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a • NC Clinical Coverage Policies 1C-1, Podiatry Services, 1C-2, Medically Necessary Routine Foot Care
Physical therapy	• SSA, Title XIX, Section 1905(a)(11) – 42 U.S.C. § 1396d(a)(11) • 42 CFR § 440.110 • NC Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e • NC Medicaid Clinical Coverage Policies 5A, Durable Medical Equipment; 5A-1, Physical Rehabilitation Equipment and Supplies; 10A, Outpatient Specialized Therapies, 10B, Independent Practitioners
Prescription drugs and medication management	• SSA, Title XIX, Section 1905(a)(12) – 42 U.S.C. § 1396d(a)(12) • 42 CFR § 440.120 • NC Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h • NC Preferred Drug List • NC Beneficiary Lock -in Program • NC Medicaid Clinical Coverage Policies 9, Outpatient Pharmacy Program; 9A, Over-the-Counter-Products; Policy 9B, Hemophilia Specialty Pharmacy Program; Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17; 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Private duty nursing services	• SSA, Title XIX, Section 1905(a)(8) – 42 U.S.C. § 1396d(a)(8) • 42 CFR § 440.80 • NC Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b • NC Clinical Coverage Policies 3G-1, Private Duty Nursing for Beneficiaries Aged 21 and Older; 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age
Prosthetics, orthotics, and supplies	• SSA, Title XIX, Section 1905(a)(12) – 42 U.S.C. § 1396d(a)(12) • 42 CFR § 440.120 • NC Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
	• NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Reconstructive surgery	• NC Clinical Coverage Policies 1-O-1, Reconstructive and Cosmetic Surgery; 1-O-2, Craniofacial Surgery; 1-O-3, Keloid Excision and Scar Revision; 1-O-5: Rhinoplasty and/or Septorhinoplasty
Respiratory care services	• SSA, Title XIX, Section 1905(a)(20) – 42 U.S.C. § 1396d(a)(20) • SSA, Title XIX, Section 1902(e)(9)(A) – 42 U.S.C. § 1396a(e)(9)(A) • NC 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 Policies 5A-2, Respiratory Equipment and Supplies; 10D, Independent Practitioners Respiratory Therapy Services
Rural health clinic services	• SSA, Title XIX, Section 1905(a)(9) – 42 U.S.C. § 1396d(a)(9) • 42 CFR § 405.2411 • 42 CFR § 405.2463 • 42 CFR § 440.20 • NC 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 aged 65 or older in an institution for mental disease (IMD)	• SSA, Title XIX, Section 1905(a)(14) – 42 U.S.C. § 1396d(a)(14) • 42 CFR § 440.140 • NC 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 CFR § 440.110 • NC Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 • NC Clinical Coverage Policies 10A, Outpatient Specialized Therapies; 10B, Independent Practitioners (IP)
Telehealth, virtual patient communications and remote patient monitoring	• 42 CFR § 410.78 • NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring
Tobacco cessation counseling for pregnant women	• SSA, Title XIX, Section 1905(a)(4)(D) – 42 U.S.C. § 1396d(a)(4)(D) • NC Medicaid State Plan, Att. 3.1-A, Page 2
Transplants and related services	• NC Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 • NC Clinical Coverage Policies 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia; 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia; 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia; 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias; 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors; 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation

Summary of Medicaid Covered Services and Applicable Clinical Coverage Policies and Other Regulations	
SERVICE	**KEY REFERENCES**
	for Hodgkin Lymphoma; 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis; 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms; 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma; 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma; 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells; 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood; 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL); 11A-17, CAR-T Cell Therapy; 11B-1, Lung Transplantation; 11B-2, Heart Transplantation; 11B-3, Islet Cell Transplantation; 11B-4, Kidney Transplantation; 11B-5, Liver Transplantation; 11B-6, Heart/Lung Transplantation; 11B-7, Pancreas Transplant; 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Ventricular assist device	• NC Medicaid State Plan, Att. 3.1-E, Page 2 • NC Clinical Coverage Policy 11C, Ventricular Assist Device
Vision services	• NC 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 Policies 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21; 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older
1915(i) option services	• NC Clinical Coverage Policies 8H-1, Supported Employment for IDD and TBI; 8H-2, Individual Placement and Support (IPS); 8H-3, Individual and Transitional Support (ITS); 8H-4, Respite; 8H-5, Community Living and Supports (CLS); 8H-6, Community Transition

NC Innovations Waiver Services

Vaya manages the following HCBS under the NC Innovations Waiver. For details, see NC Medicaid CCP 8-P:

- Assistive Technology
- Benefits Counseling
- Community Living and Support
- Community Navigator
- Community Networking
- Community Transition
- Crisis Services
- Day Supports
- Financial Support Services
- Home Modifications
- Individual Goods and Services
- Natural Supports Education
- Residential Supports
- Respite
- Specialized Consultation Services
- Supported Living
- Supported Employment

- Vehicle Modifications

In Lieu of Services

In lieu of services (ILOS) are medically appropriate, cost-effective substitutions for services or settings covered by NC Medicaid. Members have the right to refuse ILOS and request the original NC Medicaid State Plan or waiver service instead. ILOS definitions are available on our Provider Central website. Vaya offers the following ILOS approved by NCDHHS:

- Acute and Subacute Services Provided in an Institute for Mental Disease
- Family-centered Treatment
- High-fidelity Wraparound
- Long-term Community Supports
- Outpatient Plus
- Transitional Youth Services
- Enhanced Crisis Response
- Rapid Care
- Child-Focused ACT
- Behavioral Health Crisis Risk Assessment and Intervention
- ACT Team Step Down
- In-Home Therapy Services
- Residential Services – Complex Needs

State-funded Behavioral Health, I/DD, and TBI Services

Vaya manages the following State-funded (non-Medicaid) behavioral health, I/DD, and TBI services for Tailored Plan recipients. For details, see the NCDHHS State-Funded Service Definitions webpage.

State-funded Behavioral Health, I/DD, and TBI Services

DISABILITY GROUP	CORE SERVICES	NON-CORE SERVICES
All-disability	• Diagnostic Assessment • Facility-based Crisis (FBC) for Adults • Inpatient Behavioral Health Services • Mobile Crisis Management (MCM) • Outpatient Services	• Behavioral Health Urgent Care • FBC for Children and Adolescents
Adult mental health	• ACT • Assertive Engagement • Case Management • Community Support Team (CST) • Peer Support Services • Psychosocial Rehabilitation • Mental Health Recovery Residential Services • Individual Placement and Support – Supported Employment (IPS-SE) • Transition Management Services • Critical Time Intervention • Behavioral Health Comprehensive Case Management	• Partial Hospitalization

State-funded Behavioral Health, I/DD, and TBI Services		
DISABILITY GROUP	**CORE SERVICES**	**NON-CORE SERVICES**
Child Mental Health	• High-fidelity Wraparound • Intensive In-home • Multisystemic Therapy • Respite • Assertive Engagement	• Mental Health Day Treatment
I/DD and TBI	• Residential Supports • Day Supports Group • Community Living and Support • Supported Living Periodic • Supported Employment • Respite • Adult Day Vocational Program (ADVP)	• TBI Long-term Residential Rehabilitation Services
Substance Use Disorder - Adult	• Ambulatory Detoxification • Assertive Engagement • Case Management • Clinically Managed Population Specific High-intensity Residential Services • Outpatient Opioid Treatment • Non-hospital Medical Detoxification • Peer Supports • Substance Use Residential Services and Supports • Substance Abuse Halfway House • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Substance Abuse Medically Monitored Community Residential Treatment • Substance Abuse Non-Medical Community Residential Treatment • Individual Placement and Support (Supported Employment) • CST • Behavioral Health Comprehensive Case Management	• Social Setting Detoxification Services
Substance Use Disorder - Child	• Multisystemic Therapy • Substance Abuse Intensive Outpatient Program • Substance Use Residential Services and Supports • High-fidelity Wraparound • Assertive Engagement	• Intensive In-home • Day Treatment Child and Adolescent • Respite

Pharmacy Services

Vaya covers pharmacy benefits for Vaya Total Care members. We delegate retail pharmacy authorizations and billing to our Pharmacy Benefit Manager, Navitus Health Solutions (see page 3 of this manual for contact information). Our

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 NC Medicaid Preferred Drug List (PDL)

Information about Vaya's pharmacy benefits may be found on our Pharmacy webpage, including:

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

NC Medicaid PDL

Vaya has adopted the NC Medicaid PDL, which 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. Medications are selected based on their efficacy data, safety profile, published clinical literature, and cost-effectiveness. Generic medications must be dispensed when available and on the PDL.

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 on Vaya's Provider Central website.

The NC Medicaid PDL Review Panel meets at least quarterly to discuss recommended policies and procedures related to the PDL and to address public comments received during the PDL comment period. NC Medicaid posts recommended changes to the PDL prior to each meeting and accepts written public comments for a 30-day period. For instructions for submission of public comments on the PDL and other clinical policies, visit the NC Medicaid Proposed Medicaid Policies webpage.

Coverage Limitations and Medication-Specific Limits

Vaya's Tailored Plan for Medicaid members (Vaya Total Care) 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 CCPs 9 and 9A for details):

- Products that are experimental, investigational, or part of a clinical trial
- Over-the-counter 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 (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
- Cough/cold products that contain an expectorant or cough suppressant

The NC Medicaid P&T Committee may impose medication-specific limits to optimize medication safety and promote cost-effective care. Prescribers may request exceptions with member-specific clinical justification by calling the Pharmacy Service Line (1-800-540-6083) or completing the Medical Exceptions Form available on Provider Central. 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, the member (or the prescriber, with written permission) 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. For details on the appeals process, see Section 2, Clinical Practice Standards and UM Program.

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. A list of medications covered under the PADP, and the corresponding fee scheduled is available on the NCDHHS website. To access the list of medications requiring prior authorization, prior authorization forms, and CCPs, visit the NC Medicaid Program Specific Clinical Coverage Policies webpage.

SECTION 2

Clinical Practice Standards and UM Program

Clinical Practice Guidelines and UM Program Policy

Vaya maintains a UM program for physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy services that is based on nationally recognized, evidence-based clinical practice guidelines and decision support methodologies. **For full details, review our UM Program Policy and Clinical Practice Guidelines and Leveling Tools.**

Services must meet medical necessity criteria and the general coverage requirements below. Medically necessary services are defined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. Medically necessary services must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

General coverage requirements include:

- 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;
- The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
- The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider;
- The member meets program eligibility requirements;
- The procedure, product, or service does not duplicate another provider's procedure, product, or service;
- The procedure, product, or service is not experimental, investigational, or part of a clinical trial; and
- Any specific criteria set forth in the applicable NC Medicaid CCP, Vaya CCP, or NCDHHS-defined standards.

Practitioners may freely communicate with members about their treatment, regardless of benefit coverage limitations. Vaya's compensation structure for employees and contractors who perform UM activities does not provide incentives to deny, limit, or discontinue medically necessary services to any member.

Admissions and Notifications

To support care management, Vaya requires admission notifications for the following service types:

- **Physical Health – Acute Inpatient:** Submission of a notification SAR in the Provider Portal is required within 48 hours of admission.
- **Behavioral Health – Inpatient:** Submission of a notification SAR in the Provider Portal is required within 48 hours of admission.

Authorization and Utilization Review

SARs must demonstrate medical necessity and include documentation required by NC Medicaid CCPs, applicable Medicaid waivers, State-funded service definitions, and Vaya's Authorization Guidelines. With limited exceptions, providers must submit SARs via the Provider Portal.

If the Provider Portal is not functioning or available, Vaya may accept SARs via fax, U.S. mail, or hand delivery. Providers must maintain a record of the SAR submission date. SAR forms are available on our Prior Authorization webpage.

Some NC Medicaid CCPs and waivers (e.g., the NC Innovations Waiver) require Vaya to review annual service plans. When required, providers must submit the plan to Vaya following the initial assessment, at least annually thereafter, and whenever significant changes occur in the member's situation and/or plan of care.

Authorization does not guarantee payment. Payment is subject to other requirements and limitations set forth in your contract, this manual, and any other guidance published by Vaya. For assistance with authorizations, contact our UM Team at um@vayahealth.com or 1-800-893-6246, ext. 1515 (behavioral health) or 1526 (physical health).

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Vaya reviews all requests for Medicaid members under age 21 using EPSDT criteria. Services approved under EPSDT must be listed in Section 1905(a) of the Social Security Act, which does not include most Innovations Waiver and 1915(i) services, and must:

- Be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition that is identified through a screening examination
- Be medical in nature
- Be generally recognized as an accepted method of medical practice or treatment
- Not be experimental or investigational
- Be safe and effective

EPSDT does not eliminate prior authorization requirements. Under EPSDT, limitations on hours, units, and visits that apply to adults may not apply to children. However, the Innovations Waiver annual budget limit cannot be exceeded under EPSDT. To request services under the EPSDT benefit, providers must submit the EPSDT Non-Covered Service Request Form available on our EPSDT webpage.

Prior Authorization

Visit our Authorization Guidelines webpage for prior authorization requirements for behavioral health, I/DD, TBI, LTSS, and physical health services. Visit our Pharmacy Prior Authorization page for pharmacy information.

For non-pharmacy services requiring prior authorization, providers must submit a SAR at least 14 calendar days prior to the requested service start date, except for expedited requests. For concurrent/continued stay requests for routine services, providers must submit a SAR 14 calendar days prior to the end of the current authorization.

UM may request additional information if a SAR is incomplete. Providers have up to three business days to submit any requested additional information. Vaya will return incomplete SARs as "unable to process." Ninety percent of providers' monthly SAR submissions must be complete and include all administrative requirements. (Vaya administratively denies SARs that do not include all administrative requirements and clinically denies SARs that do not meet medical necessity or general coverage requirements described above.)

Peer Review

The UM Team refers non-pharmacy service requests that a Vaya clinician or nurse is unable to approve to a licensed, doctoral-level psychologist (for behavioral health, I/DD, or TBI services only) or physician for peer review. The Peer Reviewer may contact the provider to obtain additional information. 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 reach the provider, they will make a decision based on the information submitted with the SAR.

Peer-to-Peer Discussions

If Vaya issues a medical necessity denial, the ordering or attending provider may request a peer-to-peer discussion within three business days of the denial notice. If the Peer Reviewer who made the decision is not available, Vaya will make an equally qualified Peer Reviewer available. Peer-to-peer discussions are not appeals. Rather, they provide an opportunity to discuss the decision and reasons for the denial. The member or their legally responsible person (LRP) still has appeal rights and must file a formal appeal with Vaya to request that we overturn the denial. The provider may request an appeal on the member's behalf if Vaya has the member's written consent for the provider to appeal the specific service authorization decision.

Member and Provider Notifications

The SAR review may result in a full approval, partial approval, or a full administrative and/or clinical denial. For standard reviews, Vaya will issue a decision within 14 days. Under certain circumstances, we may extend this timeframe up to 14 additional days.

Upon SAR approval, Vaya generates an electronic authorization notice in the Provider Portal. The provider is responsible for notifying the member when a service is approved. Vaya does not send notifications to members unless the request is fully or partially denied. In these cases, Vaya sends the member a notice via U.S. mail that includes information about appeal rights and an Appeal Request Form.

The effective date of the decision is the date the notice is mailed, except when Vaya terminates, reduces, or suspends an authorization before the current authorization expires. In this instance, the effective date will be no sooner than 10 days after the date the notice is mailed.

Expedited Review

Providers may request expedited SAR review if they believe the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. The request must include clinical justification of the risk of harm. Vaya completes reviews of requests that meet expedited review criteria within 72 hours.

Second Opinion

A Medicaid member, their LRP, or a member of their health care team who disagrees with their diagnosis, treatment, or prescribed medication has the right to request a second opinion. Vaya informs members of this right in the Vaya Tailored Plan Member Handbook and the Vaya NC Medicaid Direct Member Handbook, as well as on the Vaya website.

Vaya will provide for a second opinion from a qualified health care professional in our network or arrange for the member to obtain one outside the network if there is not a participating provider with appropriate expertise required for the member's condition, at no cost to the member. Vaya does not require prior authorization for second opinions. Out-of-network (OON) providers must contact Vaya to execute an OON agreement or contract prior to rendering services by emailing provider.info@vayahealth.com.

Upon request by the member, the second health care professional with appropriate written member consent, or Vaya, you must provide the first-opinion records ahead of the member's appointment for the second opinion.

Retrospective Authorization

If a member did not have Medicaid at the time the service was provided but later gains eligibility that covers the dates of service, providers may request retrospective authorization by submitting the SAR and all documentation no later than 90 days following the notification of the Medicaid eligibility determination.

Clinical records may be submitted via secure fax to 828-348-4141. Providers must include any authorization information from other insurers with the request.

Emergency and Post-Stabilization Services

This subsection is applicable to all hospitals, 24-hour inpatient facilities (excluding Psychiatric Residential Treatment Facilities [PRTFs]), and emergency and crisis stabilization service providers who receive reimbursement from Vaya.

Emergency services, as defined at 42 CFR § 438.114(a), do not require prior authorization. Vaya will cover and pay for emergency services for eligible Medicaid member, without regard to prior authorization or Vaya network status. Vaya will also not deny payment for treatment obtained when a member had an emergency medical condition.

"Emergency services" means covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant person, the health of the person or unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

We do not limit what is considered an emergency medical condition based on lists of diagnoses or symptoms. We consider MCM and emergency ambulatory services to generally fall within this definition.

"Post-stabilization care" services generally mean covered inpatient and outpatient services that maintain stabilization of the emergency medical condition or improve or resolve the member's condition. Post-stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR § 438.114(a) and (e) and 42 CFR § 422.113(c).

Providers must request reimbursement for emergency services from Vaya within 365 days of treatment or discharge (whichever is later). For OON providers, we will ask you to complete a billing enrollment form and IRS W-9 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.**

You must notify Vaya within 24 hours when a member is transferred or discharged from the emergency department (ED).

When 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 seven calendar days of discharge with the individual's behavioral health clinical home, or, if there is no behavioral health clinical home, with an appropriate outpatient or other behavioral health

provider. Vaya Member and Recipient Services staff can help arrange the follow-up appointment for members who are not yet connected with behavioral health services. Please call the Member and Recipient Service Line 1-800-962-9003 for assistance with behavioral health appointments.

Criterion 5 Continued Stay

When a Vaya Medicaid member age 17 or younger who is receiving inpatient behavioral health services meets discharge criteria, but post-discharge medically necessary services are not available in the community, the treating clinician/service provider at the acute care facility must request continuation of inpatient services under Criterion 5 (see NC Medicaid CCP 8-B, Inpatient Behavioral Health Services). If not all criteria for a continued acute stay in an inpatient psychiatric facility as specified in 10A NCAC 25C. 0302 are met, and the Medicaid member will remain at the acute care facility, the provider may receive payment at Vaya's established rate for continued stay in the facility at a post-acute level of care. The service provider at the acute care facility must submit the Criterion 5 Services Needs/Discharge Planning Status Form, available on our Forms webpage, with an attached copy of the hospital discharge plan to Vaya for prior authorization for additional time in the hospital in anticipation of discharging to community services.

Personal Care Services (PCS)

Eligible Tailored Plan Medicaid members may qualify for PCS to help them with Activities of Daily Living (ADLs). Members must complete an independent assessment to determine PCS program eligibility. To access the assessment request form or get more information, visit our Personal Care Services webpage or contact the Vaya PCS Independent Assessment Team at 1-877-290-6315.

Durable Medical Equipment (DME)

DME refers to the following categories of equipment and related supplies for use in a Medicaid member's home:

- Inexpensive or routinely purchased items
- Capped rental/purchased equipment
- Equipment requiring frequent and substantial servicing
- Oxygen and oxygen equipment
- Related medical supplies service and repair
- Other individually priced items
- Enteral nutrition equipment

For the Innovations Waiver: DME providers must submit a request for approval under the applicable DME policy (NC Medicaid CCP 5A-1, 5A-2, 5A-3, or 5B) prior to requesting a service to be covered under the Innovations Waiver as Assistive Technology, Equipment, or Supplies (ATES) or a Home Modification.

For full DME requirements, review the NC Medicaid CCPs.

Member and Recipient Appeals

Network providers are responsible for understanding and helping members with the appeal process. Vaya does not retaliate in any way against a member or provider who requests an appeal or expedited review. Appeal requests may be submitted using the contact information included on the adverse decision 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 office, 200 Ridgefield Court, Suite 218, Asheville, NC 28806

The appeal process below also applies to adverse decisions issued by subcontractors delegated to perform utilization management functions on Vaya's behalf. 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

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

Members must go through the Vaya appeals process before filing a Medicaid appeal with the North Carolina Office of Administrative Hearings (OAH). Detailed information about the process is included in the Vaya Tailored Plan Member Handbook and Vaya NC Medicaid Direct Member Handbook available at vayahealth.com.

Vaya sends an acknowledgement letter when we receive an appeal request, unless an expedited appeal is requested and accepted. Vaya sends a Notice of Receipt of Appeal Request to the member or LRP/authorized representative within five days of receipt of a valid written or oral request. A health care professional with appropriate clinical expertise in treating the member's condition or disorder who was not involved in the original decision and is not a direct subordinate of the initial decisionmaker decides the appeal outcome. A member or LRP can request a copy of the clinical rationale and/or the appeal case file from Vaya at any time. They also may submit new or additional information for Vaya to consider, provided it is received before the health care professional renders a decision.

Vaya issues a written Notice of Decision within 30 days of receipt of a timely and valid 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 an appeal review if we agree a member or LRP's request for an expedited review meets established criteria or that 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 cannot appeal the denial to expedite the request.

Extension of Appeals Timeframes

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 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, which may be terminated if NCDHHS determines a member no longer meets 1915(i) service eligibility, there is no "maintenance of service" under any Vaya's health plan. However, if Vaya reduces, suspends, or terminates a previously authorized service, the member may continue to receive the service if **all** following conditions are met:

- Vaya receives a timely request for appeal;
- The member remains eligible for Medicaid;
- The service was ordered by an authorized provider;
- The authorization period for the service 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.

When the above conditions are met, the service may 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 NCDHHS (or its designated vendor) determines 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 service" if the member appeals their eligibility termination.

State-Funded Service Appeals

Recipients of State-funded services who wish to appeal an adverse decision 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 may file an appeal with DMHDDSUS 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 DMHDDSUS. There is no "maintenance of service" or "continuation of benefits" for State-funded services.

SECTION 3

Network Adequacy and Access Standards

Open and Closed Networks

Vaya maintains a sufficient network of high-quality service providers that meets member and community needs within available resources. **Vaya operates an open network and accepts providers who are enrolled in NCTracks, meet objective quality standards, and accept network rates, except for certain services as set forth in N.C.G.S. § 108D-23(c).** To meet NCDHHS availability, accessibility, and quality goals and requirements, Vaya negotiates with any willing provider, except for providers of the following services, which are not available through Standard Plans and for which we maintain a closed network:

- Assertive Community Treatment (ACT)
- Child and Adolescent Day Treatment
- CST
- Innovations Waiver services
- Intensive In-Home services
- ICF/IID services
- Multisystemic Therapy
- PRTF
- 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 wishing to enroll in the closed network if we have enough providers with the same or similar qualifications and credentials to provide adequate access to all services.

Vaya Provider Network Operations Department representatives meet at least annually to develop recommendations for renewals of existing contracts from a cross-functional perspective. Vaya makes decisions about contract renewals in accordance with the written selection and retention criteria as required by 42 CFR § 438.214.

Network Adequacy Time and Distance Standards

Vaya ensures our provider network meets time and distance standards established by the U.S. Centers for Medicare & Medicaid Services (CMS), NC Medicaid, and DMHDDSUS. Vaya complies with any new standards adopted by NCDHHS, either through an amendment or as directed through formal notice.

Vaya's provider network 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 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 ages 21 and older, and pediatric (child) services are those provided to members under age 21. For purposes of network adequacy standards for behavioral health, I/DD, and TBI providers, except as otherwise indicated in the CCP, adult services are those provided to members ages 18 and older, and pediatric/adolescent (child) services are those provided to members under age 18.

Most services are available within 30-45 miles or 30-45 minutes driving time. Vaya supports at least one behavioral health walk-in center in every county in our region. However, because of insufficient demand and economy of scale factors, some specialty providers may be located outside this radius, or there may be only one provider available to deliver the needed service.

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 (MEDICAID)

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
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
Obstetrics	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 (MEDICAID)		
SERVICE TYPE	**URBAN STANDARD**	**RURAL STANDARD**
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 (RB-BHT) 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 • *RB-BHT for ASD: Not subject to standard*
Location-Based Services	• Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment: Greater than or equal to two providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • *Child and Adolescent Day Treatment Services: Not subject to standard*	• Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment: Greater than or equal to two providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • *Child and Adolescent Day Treatment Services: Not subject to standard*
Crisis Services	• Professional treatment services in an FBC program: the greater of: ○ Two or more facilities in the Vaya region OR ○ One facility in the Vaya region per 450,000 total regional population (as estimated by combining North Carolina Office of State Budget and Management county estimates) • FBC services for children and adolescents: Greater than or equal to one provider within the Vaya region • Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification): Greater than or equal to two providers within the Vaya region • Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification), Ambulatory Withdrawal Management with Extended On-site Monitoring, Clinically Managed Residential Withdrawal Services (social setting detoxification), MCM: Greater than or equal to two providers of each service within the Vaya region	
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
Community/ Mobile Services	Greater than or equal to two providers of community/mobile services within the Vaya region. Each county in region must have access to greater than or equal to one provider that is accepting new patients.	

TIME AND DISTANCE STANDARDS (MEDICAID)		
SERVICE TYPE	**URBAN STANDARD**	**RURAL STANDARD**
All State Plan LTSS (except Nursing Facilities and 1915[i] Services)	Greater than or equal to 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), identified by distinct National Provider Identifier (NPI), accepting new patients and available to deliver each State Plan LTSS in every county	
Nursing Facilities	Greater than or equal to one nursing facility accepting new patients in every county	

Residential Treatment Services	• Residential Treatment Facility Services: Greater than or equal to one licensed provider within the Vaya region
	• Medically Monitored Intensive Inpatient Services (substance abuse medically monitored residential treatment): Greater than or equal to one licensed provider within the Vaya service region (refer to 10A NCAC 27G.3400)
	• Clinically Managed Residential Services (substance abuse non-medical community residential treatment):
	  ○ Adult: Greater than or equal to one licensed provider within the Vaya service region (refer to licensure requirements to be determined by NCDHHS; not subject to standard until 90 calendar days after licensure requirements are established)
	  ○ Adolescent: All designated Cross-Area Service Programs (CASPs) statewide
	  ○ Women and children: All designated CASPs statewide
	• Clinically Managed Population-Specific High-Intensity Residential Program: All designated CASPs statewide
	• Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house):
	  ○ Adult: Greater than or equal to one male and one female program within the Vaya region (refer to 10A NCAC 27G.5600E)
	  ○ Adolescent: Greater than or equal to one program within the Vaya region (refer to 10A NCAC 27G.5600)
	• *PRTF and ICF/IID: Not subject to standard*
	• *Medically Monitored Intensive Inpatient Services (once policy is added)*	

1915(c) HCBS Waiver Services: NC Innovations	• Community Living and Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: Greater than or equal to two providers of each service within the Vaya region • Crisis Intervention and Stabilization Supports, Day Supports, Financial Support Services: Greater than or equal to one provider of each service within the Vaya region • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modifications: Not subject to standard*	
Employment and Housing Services	Individual Placement and Support (IPS) – Supported Employment (adult mental health): Greater than or equal to two provider agencies within the Vaya region. Each county in the Vaya region must have access to one or more providers that is accepting new patients	
1915(i) HCBS	• Community Living and Support, Individual and Transitional Support, Out-of-Home Respite, Supported Employment (for members with I/DD and TBI), Individual Placement and Support (for members with a qualifying mental health condition or substance use disorder): Greater than or equal to two providers of each 1915(i) service within the Vaya region	

TIME AND DISTANCE STANDARDS (MEDICAID)		
SERVICE TYPE	**URBAN STANDARD**	**RURAL STANDARD**
	• In-Home Respite: Greater than or equal to two providers within 45 minutes of the member's residence	

SERVICE CATEGORIES FOR BEHAVIORAL HEALTH TIME AND DISTANCE STANDARDS	
SERVICE CATEGORY	**SERVICES FALLING WITHIN THE CATEGORY**
Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children) • Diagnostic Assessment • Research-based Behavioral Health Treatment for Autism Spectrum Disorder (ASD)
Location-Based Services	• Psychosocial Rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Opioid Treatment Program (OTP) (adult) • Child and Adolescent Day Treatment services
Crisis Services	• FBC services for children and adolescents • Professional Treatment Services in an FBC program (adult) • Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification) • Ambulatory Withdrawal Management with Extended On-Site Monitoring • Clinically Managed Residential Withdrawal Services (social setting detoxification) • Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification)(adult) • MCM
Inpatient Behavioral Health Services	**Inpatient Hospital – Adult** • Acute care hospitals with adult inpatient psychiatric beds • Medically Managed Intensive Inpatient Withdrawal Management (acute care hospitals with adult inpatient substance use beds) • Medically Managed Intensive Inpatient Services (acute care hospitals with adult inpatient substance use beds) **Inpatient Hospital – Adolescent/Child** • Acute care hospitals with adolescent inpatient psychiatric beds • Medically Managed Intensive Inpatient Services (acute care hospital with adolescent inpatient substance use beds) • Acute care hospitals with child inpatient psychiatric beds
Partial Hospitalization	Partial Hospitalization (adults and children)
Residential Treatment Services	• Residential Treatment Facility Services • Medically Monitored Intensive Inpatient Services (substance abuse medically monitored residential treatment) • Clinically Managed Residential Services (substance abuse non-medical community residential treatment) • Clinically Managed Population-Specific High-Intensity Residential Program

SERVICE CATEGORIES FOR BEHAVIORAL HEALTH TIME AND DISTANCE STANDARDS	
SERVICE CATEGORY	**SERVICES FALLING WITHIN THE CATEGORY**
	• Clinically Managed Low-Intensity Residential Treatment Services (substance use halfway house) • PRTF • ICF/IID
Community/Mobile Services	• ACT • CST • Intensive In-Home (IIH) services • Multisystemic Therapy (MST) services • Peer Support Services • Diagnostic Assessment
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 • Supported Employment • Supported Living • Vehicle Modifications
Employment and Housing Services	Individual Placement and Support – Supported Employment (adult mental health)
1915(i) HCBS	• Community Living and Support • Community Transition • Individual and Transitional Supports • Respite • Supported Employment for members with IDD/TBI) • Individual Placement and Support (for members with a qualifying mental health condition or substance use disorder)

TIME AND DISTANCE STANDARDS (STATE-FUNDED SERVICES)		
Service Type	**Urban Standard**	**Rural Standard**
Outpatient Behavioral Health Services	• Greater than or equal to two providers of each service within 30 minutes or 30	• Greater than or equal to two providers of each service within 45 minutes or 45

TIME AND DISTANCE STANDARDS (STATE-FUNDED SERVICES)		
Service Type	**Urban Standard**	**Rural Standard**
	miles of residence for at least 95% of recipients • *RB-BHT: Not subject to standard*	miles of residence for at least 95% of recipients • *RB-BHT: Not subject to standard*
Location-Based Services	• Psychosocial Rehabilitation, SACOT, SAIOP, OTP: Greater than or equal to two providers of each service within 30 minutes or 30 miles of residence for at least 95% of recipients • *Child and Adolescent Day Treatment Services: Not subject to standard*	• Psychosocial Rehabilitation, SACOT, SAIOP, OTP: Greater than or equal to two providers of each service within 45 minutes or 45 miles of residence for at least 95% of recipients • *Child and Adolescent Day Treatment Services: Not subject to standard*

Crisis Services	• FBC (adults): The greater of:
	  ○ Two or more facilities within the Vaya region, OR
	  ○ One facility within the Vaya region per 450,000 total regional population
	• Non-Hospital Medical Detoxification: Greater than or equal to two providers within the Vaya region
	• Ambulatory Detoxification: Greater than or equal to one provider of each service within the Vaya region	

Inpatient Behavioral Health Services	Greater than or equal to one provider within the Vaya region	
Community/Mobile Services	• For each service, 100% of eligible recipients must have a choice of two provider agencies within the Vaya region. Each county in the region must have access to greater than or equal to one provider that is accepting new patients. • High Fidelity Wraparound: Greater than or equal to two providers within one hour	
	Assertive Engagement: Two providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients	Assertive Engagement: Greater than or equal to two providers of the service within 45 minutes or 45 miles of residence for at least 95% of recipients

Residential Treatment Services	• Residential Treatment Facility Services: Access to greater than or equal to one licensed provider in the Vaya region
	• Substance Abuse Halfway House:
	  ○ Adult: At least one male and at least one female program in the Vaya region
	  ○ Adolescent: At least one program in the Vaya region
	• Substance Abuse Medically Monitored Community Residential Treatment: Greater than or equal to one licensed provider
	• Substance Abuse Non-Medical Community Residential Treatment:
	  ○ Adult: Greater than or equal to one licensed provider on the Vaya region (refer to licensure requirements to be determined by NCDHHS; not subject to standard until 90 calendar days after licensure requirements are established)
	  ○ Adolescent: All designated CASPs statewide
	  ○ Women and Children: All designated CASPs statewide
	• Substance Use Residential Supports and Mental Health Recovery Residential Services: To be determined	

TIME AND DISTANCE STANDARDS (STATE-FUNDED SERVICES)		
Service Type	**Urban Standard**	**Rural Standard**
Employment and Housing Services	• Residential Services (I/DD, TBI, and adult mental health), Respite, Individual Placement and Support (I/DD, TBI, and substance use): At least two provider agencies within the Vaya region; each county in region must have access to at least one provider that is accepting new patients. • IPS-SE (adult mental health): Two provider agencies within the Vaya region; each county in the region must have access to at least one provider that is accepting new patients. • I/DD and TBI Day Supports, Community Living and Support, I/DD and TBI Residential Services, I/DD Supported Employment: At least one provider agency within the Vaya region • Clinically Managed Population-specific High Intensity Residential Programs: To be determined • TBI Long-term Residential Rehabilitation Services: To be determined	

SECTION 4

Network Requirements

Contracting and Enrollment

NCDHHS is responsible for the credentialing and re-credentialing of all providers of NC Medicaid and State-funded services. NCDHHS, or its designated vendor, collects information and verifies credentials through a centralized process. Vaya follows the Department's Uniform Credentialing and Re-credentialing Policy and Objective Quality Standards. For more information, visit the NCTracks Provider Enrollment webpage.

All providers must be enrolled in NCTracks to be eligible for enrollment in the Vaya provider network. Federal law and our contracts with NCDHHS allow us to limit participation in our closed provider network for certain behavioral health, I/DD, and TBI services. These providers are eligible for enrollment only when Vaya has identified a specific service need. For more information, see "Closed Network Enrollment and Retention Criteria" below.

Vaya makes network contracting decisions for providers of Medicaid physical health services and open network behavioral health, I/DD, and TBI services based solely upon the provider's active status on the daily Provider Enrollment File and the provider's acceptance of our contracting terms and rates.

To request to enroll in the Vaya provider network, complete and submit a Provider Contract Request Form through our Provider Enrollment webpage. At the time of contracting, providers must submit the following information to Vaya:

- Primary contact information for business functions
- W-9
- Electronic Funds Transfer Form
- Trading Partner Agreement
- Software platform agreement (to use Vaya's Provider Portal)
- Current TIN(s), NPI(s), and service locations roster (or professional groups, hospitals/health systems and Clinically Integrated Networks)

All network providers must execute a written agreement with Vaya before any services can be reimbursed. These agreements must be in your official legal name, as identified on the North Carolina Secretary of State database (for entities), or other legal form of identification (for independent practitioners). If Vaya approves an 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 end on 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 their contract profile includes an accurate list of the sites, services, and codes they are enrolled to deliver and that aligns with their NCTracks profile.

To request to change a site address or other address in an existing contract, submit a completed Provider Change Form. To request to add a new clinician to an existing organization, submit a completed Enrollment Initiation Form. To request to change a site address or other address in an existing contract with Vaya, submit a completed Provider Change Form. Enrollment forms are accessible through our Provider Enrollment webpage.

For help, contact our Provider Enrollment Services Team at 1-855-432-9139 or ProviderEnrollment@vayahealth.com.

Vendor Network Enrollment

Vaya contracts with vendors that manage provider enrollment in their respective networks for the following services:

- NEMT: Contact Modivcare at ncnetwork@modivcare.com.
- Pharmacy: Contact Navitus Health Solutions at 1-866-333-2757 or providerrelations@navitus.com.
- Vision: Contact Avēsis at 1-833-282-2427 or ProviderVisionRecruitment@avesis.com.

OON Agreements

Member-specific OON agreements are limited to closed network services (managed behavioral health, I/DD, and TBI services) and providers of open network services located more than 40 miles outside of North Carolina. Vaya enters into member-specific agreements for closed network services only if we determine a network provider cannot meet the need for geographically accessible, appropriate, and/or timely services for a specific individual. Visit our Provider Enrollment webpage to access the Member-Specific OON Agreement.

Hospitals and health systems with questions about OON agreements may contact Vaya's Utilization Management Team at 1-800-893-6246, ext. 1515, or UM@vayahealth.com.

Closed Network Enrollment and Retention Criteria

Vaya maintains a closed network for behavioral health, I/DD, and TBI services that are not available through NC Medicaid Managed Care Standard Plans. If Vaya identifies a specific service need, we may seek to add appropriate providers through means such as direct contact, solicitation of applications via the Vaya Provider Communication Bulletin or website, or a procurement process.

Initial Enrollment

Providers must meet all applicable criteria below to enroll as a new provider in the closed network. Vaya reserves the right to conduct an onsite review at any time to confirm compliance with these criteria and the right to reject any applicant whom we determined does not meet these criteria:

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 below.
4. The applicant must provide truthful, accurate information during the selection process, including in the enrollment and the NCDHHS-identified credentialing and/or re-credentialing application and process.
5. The applicant must adhere to evidence-based or best practices, where applicable, and provide culturally competent services.
6. The applicant must demonstrate efforts to implement a customer service system that ensures good communication with members and families.
7. The applicant must have a "no-reject" policy for referrals.

8. The applicant must have a robust Compliance Plan that meets the requirements of 42 CFR § 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 an electronic health record (EHR) system that is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that supports management of authorizations and billing functions. EHRs must be able to send HL7 messages (versions 2 or higher) to communicate with the North Carolina 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.

Contracting for providers of closed network services also requires the approval of Vaya's Network Services Management Committee.

Retention Criteria

Vaya may choose to renew a contract in whole 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.

In general, Vaya's policy is to renew closed network contracts unless one of the following applies: (1) renewal does not support Vaya's Comprehensive Care Center model; (2) renewal is not supported by the Network Access Plan or a detailed Market Analysis; (3) 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:

- The provider is not in compliance with applicable federal or state laws, rules or regulations, or is in breach of any provision of its current contract with Vaya, including the scope of work or requirements concerning clients' rights, confidentiality, and records retention.
- The provider has not billed for services in the 90 days prior to Vaya's review of the contract renewal, unless it concerns a provider of specialty or out-of-region services that are delivered infrequently.
- The provider is not in good standing as defined in this manual below.
- Vaya has issued two or more Plans of Correction (POCs) against the provider for the same or similar out-of-compliance findings.
- The provider has failed to implement a POC issued by Vaya, and the time for doing so has expired.
- Vaya has issued two or more sanctions or administrative actions against the provider.
- The provider has failed to remit an identified overpayment to or enter into an approved payment plan with Vaya within the designated timeframe.
- Vaya has logged quality of care concerns or other serious grievances about the provider that have not been satisfactorily resolved in required timelines.
- The provider has had a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Vaya.

- The provider has not responded to requests for data or other information necessary for Vaya to respond to requests from NCDHHS.
- The provider fails to provide proof of insurance as required under the terms and conditions of their contract.
- The provider has failed to meet Routine Post-Payment Review requirements.

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

- Demonstrated compliance with this manual, Vaya Provider Communication Bulletins, and bulletins and manuals issued by NCDHHS
- Demonstrated ability to ensure members meet medical necessity requirements for all services provided
- Efforts to achieve evidence-based or best practices in applicable areas of service, including the responsibilities associated with clinical and/or medical homes
- Acceptable agency Cultural Competency Plan, including efforts to provide culturally competent services and ensure the cultural sensitivity of staff members
- Provision of an adequate emergency response system that complies with the services being provided, including the implementation of measures to respond to emergencies on weekends and evenings for members served
- Demonstrated member-friendly services and attitude by implementing a system that ensures good communication with members and families/caregivers
- Provision of services in accordance with all applicable state and federal laws, rules, regulations, the North Carolina State Plan for Medical Assistance, applicable waivers, NC Medicaid CCPs, and/or State-funded service definitions
- Ability to meet DMHDDSUS access standards and appointment wait times
- Implementation of a “no-reject” policy for Vaya members
- Cooperation and compliance with discharge and transfer requirements to ensure a smooth transfer for any member who desires to change providers, or because the provider cannot meet their special needs
- Adherence to all documentation requirements as set forth in NC Medicaid CCPs, State-funded service definitions, and/or the RMDM
- Cooperation and participation with all Vaya program integrity activities, utilization management, quality management, compliance, and appeal and grievance procedures
- Demonstrated ability to satisfactorily complete and upload SARs that meet Vaya requirements
- Ability to meet Good Standing criteria
- Participation in member and provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements
- Demonstrated financial stability, defined as having a minimum of one month’s working capital or line of credit equal to the provider’s monthly gross income or no tax liens, as well as infrastructure to monitor all financial information of the company, including debt-to-income ratio
- An acceptable Quality Management Plan with evidence of strategies and goals being implemented
- Adequate clinical leadership according to the disability and services provided, with a sufficient supervision structure
- Demonstrated HIPAA-compliant EHR system that supports management of authorizations and billing functions and compliance with the capability to connect with the North Carolina HIE
- An acceptable 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 the application, one or more legal actions resulted in at least one judgment, one settlement of more than $50,000, or two or more settlements in an aggregate amount of $50,000 or more
- A valid and current facility license (if required)

Good Standing

All applicants for enrollment in the Vaya closed provider network must be in good standing to be considered for initial enrollment or contract renewal. **We consider a provider to be in good standing when the applicant or network provider, its owners, and managing employees meet all following criteria (please note all activities associated with continuous verification of exclusion status are the responsibility of NCDHHS):**

- Are not excluded from participation in any federal health care program;
- Have no relevant findings on criminal background checks;
- Have not received sanctions or administrative actions more than two times from any LME/MCO in the previous 12-month period;
- Do not currently and 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, the Vaya closed network, or another Medicaid managed care program involuntarily terminated for any reason;
- Do not currently and 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;
- Have 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;
- Do not owe an outstanding overpayment to Vaya or any other LME/MCO;
- Do not owe an outstanding final overpayment to NCDHHS; and
- Have 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.

Further, the provider must not be currently suspended from a Medicaid program or listed with as negative action in any of the following databases:

- 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
- Medicare Exclusion Databases
- NCTracks
- North Carolina Division of Health Service Regulation (DHSR) Health Care Personnel Registry
- North Carolina State Provider Exclusion List/NC Medicaid Program Integrity Database
- National Plan & Provider Enumeration System (NPPES)
- National Practitioner Data Bank (NPBD/HPDB)
- National Technical Information Service for U.S. Drug Enforcement Administration certificates
- Social Security Administration's Death Master File
- National Accrediting Boards (e.g., CARF, Joint Commission on Accreditation of Hospitals)
- Boards of licensure or certification for the applicable scope of practice
- Vaya Provider Exclusion/Sanction List

Good standing further means the applicant has submitted all required documents, payments and fees, including, but not limited to, outstanding tax or payroll liabilities, to U.S. HHS or any of its divisions, NCDHHS or any of its divisions, U.S. Internal Revenue Service, North Carolina Department of Revenue, North Carolina Secretary of State (if organized as a corporation, partnership or limited liability company), and North Carolina Department of Labor.

Good standing also means the applicant is not currently subject to sanctions or administrative actions or has not been subject to sanctions or administrative actions within the 12 months prior to the application or renewal decision, including, but not limited to, the following issued by:

- Vaya or other LME/MCO: Contract Termination or Suspension, Suspension of Referrals, Unresolved POC, Overpayment, Prepayment Review, or Payment Suspension;
- NC Medicaid: Contract Termination or Suspension, Payment Suspension Prepayment Review, or Final Overpayment;
- DMHDDSUS: Revocation of Authority to Receive Public Funds or Unresolved POC;
- DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active Summary Suspension, or Active Notice of Revocation or Revocation in Effect;
- North Carolina Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, or Revenue Suspension;
- Boards of licensure or certification for the applicable scope of practice; and
- Provider's selected accrediting body.

Vaya considers a sanction or an administrative action final upon notification to the provider, unless the provider timely requested an appeal review, in which case we consider the action final when the appeal review panel issues a decision. Vaya is not required to enroll an applicant in the closed 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 reserves the right to make exceptions to the good standing criteria as needed to ensure appropriate availability and accessibility of services to members.

Provider Terminations

Vaya may terminate a provider from the network with or without cause. If this occurs, we 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 (see Section 12, Provider Grievances and Appeals, 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.

Excluded Providers

NCDHHS, or its delegated vendor, uses the following resources to monitor the exclusion status of all providers enrolled in NCTracks to ensure Vaya does not pay federal funds to excluded persons or entities:

- 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.

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 Vaya employee.

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.

Nondiscrimination Statement

Vaya is committed to nondiscriminatory provider enrollment processes. Vaya does not make decisions related to the credentialing, re-credentialing, enrollment, or contracting of any provider on the basis of any protected classification or characteristic, including, but not limited to, race, color, creed, religion, ancestry, sex, gender identity, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information, health status/need for health services, marital status, parental status, or other protected status in compliance with federal and state laws that prohibit discrimination. Vaya also does not discriminate against providers or practitioners serving high-risk populations or specializing in conditions that require costly treatment or based on practitioner or facility license or certification type. This applies to all aspects of network participation, including, but not limited to, selection and retention, enrollment, contracting, audits, monitoring and investigations, adverse actions, and dispute resolution.

Nondiscrimination 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.

Cultural and Linguistic Competency and Accessibility

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 maintains a Cultural Competency Plan and requires network providers to develop and implement their own cultural competency plans that respect and support the cultural and diverse needs of members, families, stakeholders, communities, and other agencies. Providers should practice person-centered thinking and deliver services in a culturally competent manner to all members, including those with limited English proficiency and 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 to address the needs of the Medicaid population and 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.

Vaya and providers must provide free auxiliary aids and services to people with disabilities, including qualified sign language interpreters and written information in other formats, such as large print, audio, and accessible electronic formats. Vaya and providers also must offer free language services to people who primarily speak a prevalent language in North Carolina other than English, such as qualified interpreters for any language and written information in other languages prevalent in North Carolina.

If at any time Vaya discovers a provider has charged a current or potential member 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.

On-call Coverage

Vaya requires network providers to maintain appropriate after-hours and emergency coverage and to respond in a timely, appropriate manner to any member experiencing a crisis or emergency**. The hospital ED or 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 provided as follows:

Primary Care Providers (PCPs)

- After-hours coverage response times:
    - All network PCPs are required to have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner.
    - 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 calls answered by an answering service must be returned within 60 minutes.
- 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

Providers of Behavioral Health, I/DD, and TBI Basic Benefit Services

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 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 and include the provider's daytime and after-hours/emergency contact information, along with helpful strategies to mitigate a crisis. Members 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.

Providers Of Behavioral Health, I/DD, and TBI Enhanced Services

Providers of enhanced services are required to have first responder capability for the people they serve in accordance with the applicable NC Medicaid CCP for the enhanced service being provided:

- All above stipulations for basic benefit providers also apply to 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.
- 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.

Relationship Between First Responders and MCM

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.** 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 crisis plan, without success. However, ACT providers have more intensive crisis responsibilities under NC Medicaid CCP 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 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 Support (CLS)
- 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.

Appointment Access Requirements

Appointment Wait Time Standards for Medicaid

Visit Type	Standard
Primary Care	
Preventive Care Service – Adult, age 21 and older	Within 30 calendar days
Preventive Care Services – Child, birth through age 20	Within 14 calendar days for members less than 6 months old; within 30 calendar days for members 6 months or older
After-Hours Access – Emergent and Urgent	Immediately (available 24 hours a day, 365 days a year)
Urgent Care Services	Within 24 hours
Routine/Check-up Without Symptoms	Within 30 calendar days
Prenatal Care	
Initial Appointment – 1st or 2nd Trimester	Within 14 calendar days
Initial Appointment – High-risk Pregnancy or 3rd Trimester	Within five calendar days

Visit Type	Standard
Specialty Care	
After-Hours Access – Emergent and Urgent	Immediately (available 24 hours a day, 365 days a year)
Urgent Care Services	Within 24 hours
Routine/Check-up Without Symptoms	Within 30 calendar days
Behavioral Health, I/DD, and TBI Services	
Mobile Crisis Management Services	Within two hours
Facility-based Crisis Management Services (FBC for Children and Adolescents, FBC for Adults, Non-Hospital Medical Detox)	Emergency services available immediately available 24 hours a day, seven days a week
Emergency Services for Mental Health	Immediately (available 24 hours a day, seven days a week)
Emergency Services for Substance Use	Immediately (available 24 hours a day, seven days a week)
Urgent Care Services for Mental Health	Within 24 hours
Urgent Care Services for Substance Use	Within 24 hours
Routine Services for Mental Health	Within 14 calendar days
Routine Services for Substance Use	Within 48 hours

Appointment Wait Time Standards for State-funded Services

Visit Type	Standard
Mobile Crisis Management Services	Within two hours
Facility-based Crisis Management Services (FBC for Adult, Non-Hospital Medical Detox)	Immediately (available 24 hours a day, 365 days a year)
Emergency Services for Mental Health	Immediately (available 24 hours a day, 365 days a year)
Emergency Services for Substance Use	Immediately (available 24 hours a day, 365 days a year)
Urgent Care Services for Mental Health	Within 24 hours
Urgent Care Services for Substance Use	Within 24 hours
Routine Services for Mental Health	Within 14 calendar days
Routine Services for Substance Use	Within 48 hours

DMHDDSUS Behavioral Health Classifications

Classification	Definition
Emergent	The individual presents as an imminent danger to self or others or has a moderate or severe risk related to safety or supervision
Urgent	The individual presents no imminent danger to self or others, but the situation may become an emergency without prompt treatment
Routine	The individual presents with mild risk or incapacitation in one or more areas of physical, cognitive, or behavioral functioning

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.

‘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 service sites and billing office locations, 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.

PCP Assignment

A PCP is the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice selected by or assigned to the member to coordinate their care and make referrals for specialized services as needed. Members with complex conditions or special health care needs may select a specialist as their PCP. PCPs may set limits on panel size and are responsible for communicating limits and capacity for accepting referrals to Vaya’s Provider Network Operations Department. To notify us when panel capacity is full, email PCPEnrollment@vayahealth.com.

Vaya’s methodology for assigning members to a PCP includes the following components, in this order, to the extent 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
- Advanced Medical Home Plus (AMH+) status or AMH status (Tiers 2 and 3)

Vaya informs 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 with the new PCP’s name, physical address, and phone number. This information is also available through our Member and Recipient Portal.

Members may change their PCP without cause twice per year (one time within 30 days of notification of PCP assignment and one time per year thereafter) and with cause at any time. Failure to furnish accessible and appropriate medical care, services, or supplies constitutes appropriate cause, including the following examples:

- 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

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 initiate removal of a member from their panel by submitting the Primary Care Provider Request for Member Transfer Form, located on the Forms page of our Provider Central website or available by calling the Provider Support Service Line at 1-866-990-9712 or Member and Recipient Service Line at 1-800-962-9003. The PCP also must send a letter to the member with at least 30 days' notice 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 PCP re-assignment.

The PCP must retain a copy of this letter in their records. Vaya may monitor for trends in panel removal by a PCP and report any concerning trends (e.g., sex, race, ethnicity, sexual orientation) for possible monitoring or investigation.

Innovations Waiver Requirements

All Vaya members participating in the Innovations Waiver receive an Innovations Waiver Member Handbook. For more information about requirements, see NC Medicaid CCP No. 8P.

Relative as Direct Support Employee (RADSE)

Innovations Waiver service providers may employ relatives to deliver CLS within specific parameters. In general, there are only two circumstances in which a relative should provide paid supports:

- 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.

Innovations Waiver service providers must obtain prior written approval from Vaya before employing a relative to deliver services to a waiver participant under certain circumstances. Please note the OAH has determined RADSE decisions are not appealable, but you or the participant may file a grievance with Vaya if you disagree with our decision. Additional information is available on our Relative as Direct Support Employee webpage or by emailing RADSE@vayahealth.com.

Individual and Family Directed Services (IFDS)

Innovations Waiver participants or their LRPs may elect to direct some or all of their services through the IFDS option. Participants who self-direct services, as well as LRPs, Employers of Record/Managing Employers, and Representatives choose to function as a provider and are responsible for participating in and cooperating with any and all Vaya monitoring reviews, payment reviews, audits, and other investigations. For details, see our Individual and Family Directed Services webpage and IFDS Employer Handbook.

Alternative Family Living (AFL) Requirements

An AFL provider chooses to provide Residential Supports in their home to eligible members. AFL providers serving Vaya members must meet the following requirements:

- The AFL provider must be an organization, not an individual or independent practitioner.
- The AFL provider must maintain personnel files for all employees, including documentation of required trainings 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, DHSR must license the site. If serving a single member at an unlicensed site, the AFL 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 5

Provider Responsibilities

Transition, Discharge, and Provider Closures

Network providers are required to refer members for specialty care or to other network providers in response to a member request, a change in their level of care, or a change in the provider's status in the Vaya network. You must ensure continuity of care, limit potential disruption to services, and cooperate with all transition and discharge activities, including all referral and documentation requirements. It is not acceptable to discourage a member from selecting a new provider or practitioner or to charge a fee for medical records transfer.

Change in Level of Care

If you determine a member'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. It is never acceptable to maintain a member 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.

Licensed Facility Closure

In accordance with N.C.G.S. § 122C-63, providers must notify the member 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. Vaya strictly enforces these timeframes and reports any violations to 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, which part(s) or site(s), and whether you are closing all operations in North Carolina
- The date of site closure, end of operations, or effective date of specific service elimination

Vaya will send you a written confirmation of withdrawal from the network, the effective date, member transition instructions, and a form to complete to help us assist members with the transition. Additionally, you must send members a written notification of the closure with the effective date and immediately begin work to refer individuals to other providers. Vaya also will send affected members a written notice. This notification is not necessary if you did not provide any services to Vaya members 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 transition. The notice will include a form to submit within five days of receipt to help us gather required information to transition members to a new provider. Additionally, we will send affected members a letter explaining our decision and the transition process, including other available providers. Vaya will help with referrals, but transition remains primarily your responsibility.

Individuals receiving active treatment for acute or chronic behavioral and/or physical 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 their transition plan. For Vaya to authorize continuing services, you must agree to continue treatment for an appropriate duration based on 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 who have received care from the terminated provider within the six-month period immediately preceding the termination notice date, as well as members who are scheduled to receive services, unless the terminated provider is a PCP, 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 member will be assigned to a PCP, AMH+, or CMA if they do not select one within 30 calendar days
- Procedures for continuing to receive care from the terminated provider and extension limitations

Closure Responsibilities

Network providers that close operations in the Vaya network, whether the closure is voluntary or the result of termination, acquisition by another provider, non-renewal, bankruptcy, relocation to another state, or any other reason, must comply with the following requirements:

- If requested by the receiving provider, you must actively participate in treatment team, transition, and/or discharge planning meetings until such time as all members in your care are transitioned or discharged.
- You may be subject to a final post-payment review to occur within 60 days of contract non-renewal, termination, or withdrawal.
- 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 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 we do not approve the plan, we may require you to arrange to transfer electronic or paper copies of records 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.

- 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 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.

Documentation and Records Retention

All service documentation must be timely, accurate, and complete and retained for the mandated time period. Network providers are required to strictly adhere to the documentation and records retention requirements found in federal and state laws, rules, and regulations; the NC Medicaid State Plan; and NC Medicaid CCPs and DMHDDSUS State-funded service definitions. All behavioral health, I/DD, and TBI providers must follow the DMHDDSUS Provider Agency Records Retention and Disposition Manual, APSM 45-2, (the RMDM).

Upon termination from the Vaya network, providers receive a termination and transition of care packet from their Provider Network Contract Manager. The packet includes a letter acknowledging the contract termination, provider transition of care questionnaire, member transition tracking spreadsheet, clinician report, and records retention plan. Providers have five days to return the completed packet. Vaya's Records Management Team reviews records retention plans and can be reached at health.information@vayahealth.com. For additional information, see Closure Responsibilities above.

Emergencies and Disasters

If an emergency or disaster results in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, 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 will promptly respond to provider questions and concerns through either a dedicated command center or our Provider Support Service Line (1-866-990-9712).

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

We comply with all NCDHHS guidance, including on advanced payment arrangements to support providers during 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 with access to OON and telehealth providers if an appropriate participating provider is unavailable to treat them
- Increasing Medicaid Tailored Plan member access to medications by removing maximum dosage limits for required medication, including medication-assisted treatment (MAT), antipsychotics, and insulin

Other Policies and 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 requiring 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 CFR § 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 CFR §§ 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.

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. 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.

Providers play an essential role in involuntary commitment processes for inpatient and outpatient treatment. For requirements regarding your role and the overall process, see N.C.G.S. Chapter 122C, Article 5, Parts 6-8. Helpful information for providers is also available on our Provider Central website. Affidavits, forms, and other documents are available on the NCDHHS Involuntary Commitment Forms and Processes webpage.

Behavioral Health Referrals

Behavioral health, I/DD, and TBI providers are responsible for referring members to lower or higher levels of care if their needs change. You are also responsible for facilitating transition to another network provider if the member requests to change providers. Vaya's Member and Recipient Services Department can help by providing information on network providers accepting referrals. 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.

Abuse, Neglect, and Exploitation

North Carolina mandates reporting of suspected child abuse or neglect or suspected abuse, neglect, or exploitation of disabled adults. 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. State law provides 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 are protected from involvement with that staff person until the allegation is proven or disproven. You must take swift, appropriate action if the report of abuse, neglect, or exploitation is substantiated.

Pharmacy Lock-In Program

Vaya encourages the safe prescribing, dispensing, and use of controlled substances, including opioids and benzodiazepines. The Vaya Health Lock-in Program helps people with 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 Lock-In Program and restricted to receiving opioid and benzodiazepine prescriptions from up to two providers (e.g., pain management and behavioral health) and from one pharmacy. Claims submitted by other prescribers or other pharmacies will not be paid.

Providers or pharmacies may request exceptions, subject to limits, for emergency situations by calling the Pharmacy Service Line at 1-800-540-6083. For more information about the Lock-In Program, visit our Pharmacy Lock-in Program page for Vaya members.

SECTION 6

Telehealth Services

Telehealth, Virtual Patient Communications, and Remote Patient Monitoring

Telehealth is a covered plan benefit subject to limitations and administrative guidelines. Vaya supports access to care using the following electronic communications and monitoring systems:

- **Telehealth** is defined as the use of two-way, real-time, interactive audio and video to provide and support health care services when members and providers are in different physical locations.
- **Virtual patient communication** is defined as the use of technologies other than video to enable remote evaluation and consultation support between a provider and a member or between providers, including audio telephone conversations, virtual portal communications, and data transfer from a member to a provider.
- **Remote patient monitoring** is defined as the use of digital devices to measure and transmit personal health information from a member to a provider in a different location, such as monitoring of vital signs (including self-measured/reported data and remote physiologic monitoring).

Services provided via telehealth, virtual patient communication, and remote patient monitoring must be clinically appropriate; comply with all state and federal laws, including HIPAA, and record retention requirements; and 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 allowed by NC Medicaid CCP 1H or under Vaya's Local Approved Telehealth Policy. Providers are not permitted to require members to participate in telehealth if they prefer face-to-face services.

Telehealth is reimbursed when the service is included in the provider's contract with Vaya, service requirements are met, and:

- The practitioner providing the telehealth 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 and a practitioner; and
- The provider follows the billing requirements in CCP 1H and the Vaya Local Approved Telehealth Policy.

Telehealth Policies

- NC Medicaid CCP 1H (Telehealth, Virtual Communications, and Remote Patient Monitoring)
- Vaya Health Local Approved Telehealth Policy

SECTION 7

State-funded Services and Federal Block Grants

The Vaya Tailored Plan includes State-funded (non-Medicaid) behavioral health, I/DD, and TBI services for uninsured/underinsured residents of our region who cannot afford care. State-funded services are not an entitlement, and availability depends on State, federal block grant, and county funding. Vaya targets State funding toward services for individuals who meet priority population criteria due to need based on screening, triage, and referral information. Except for crisis and emergency services, the person must be a U.S. citizen or legal resident.

State-funded services generally do not include residential treatment; if funds are available, Vaya may make exceptions 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 service is designed to treat the individual's disorder; and no other funds are available.

Eligibility for State-funded Services

Network providers must interview individuals seeking State-funded services and document criteria listed below. State funds may not be used to pay for deductibles or copays. Some Vaya members with Medicaid may also qualify for State-funded services if an equivalent Medicaid service is not available.

For mental health and substance use disorder services:

- Household income must be 300 percent or less of the current federal poverty guidelines, based on family size.
- The person must be uninsured, the service is not covered by the plan and no alternative clinically appropriate service is available, or the cost-sharing associated with the service is unaffordable (as determined by Vaya).

For I/DD and TBI services:

- The person must be uninsured, the service is not covered by the plan and no alternative clinically appropriate service is available, or the cost-sharing associated with the service is unaffordable (as determined by Vaya).
- The individual must have applied for Medicaid.
- There is no minimum financial eligibility for I/DD or TBI services.

Enrollment in State-funded Services

Network providers are responsible for thoroughly investigating an individual's ability to pay prior to requesting State-funded services from Vaya, including determining the following:

- If the individual has Medicaid or may be eligible for Medicaid (you are required to help people who may be eligible apply through the county DSS)
- If the individual has Medicare or any other third-party insurance coverage, including insurance through a non-custodial parent, an employer, or the Health Insurance Marketplace (note individuals with third-party coverage may be enrolled with Vaya as the secondary payor)

- If any other payor is involved, such as worker's compensation, disability insurance, employee assistance program, court-ordered services paid for by the court or another program, non-custodial parent pursuant to a custody order, liability judgment, etc.

Network providers are required to enroll eligible individuals for State-funded services without prior screening, triage, or referral by 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. Providers must ensure enrollment data is accurate and current. Inaccurate or incomplete 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.** You must complete the eligibility determination and enrollment request prior to service provision, except for crisis services, or claims will be denied.

Federal Block Grant Restrictions and Requirements

Vaya and DMHDDSUS 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. If you receive FBG funds, your organization must respond to all Vaya and DMHDDSUS 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 or categories under which your FBG funds fall and which requirements apply to your organization.

Community Mental Health Services Block Grant (MHBG)

- 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 evidence-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

Juvenile Justice Behavioral Health Partnership (JJBH)

- A Vaya-approved evidence-based assessment must be used for all members.
- A North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) must be completed within the required timeframes.
- A release of information signed by the LRP for sharing information between the local juvenile court and the JJBH must be present.

- The youth and family must participate in completion of the person-centered treatment plan.
- There must be evidence activities with the JJBH domains are included within the individual's service record.

Substance Use Prevention, Treatment, and Recovery Services Block Grants (SUPTRSBG)

Note: This section includes general requirements applicable to all SUPTRSBG populations/programs, as well as requirements for specific populations and programs. The scope of work in your contract with Vaya may include additional requirements for specific programs or populations listed below.

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 (CCA) 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-TOPPS interviews at required intervals.

Women's Set-Aside Funding

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 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (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

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.

Programs for Individuals Identified as IV Substance Users (SUPTRSBG-IV)

- Priority admission must be given to everyone who requests and needs treatment for IV substance use. This means individuals who use IV drugs 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, they 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 individual who uses IV substances and is seeking treatment, including those receiving interim services while awaiting admission.
- The organization must notify Vaya and DMHDDSUS 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 individuals who use substances, their associates, and neighborhood residents
    - Promoting awareness among individuals who use IV drugs 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

SUPTRSBG Prevention Program

- 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.

SUPTRSBG – Work First/Child Protective Services (CPS) Initiative

- 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 CCAs. Vaya requires this individual be licensed or associate-licensed by the North Carolina 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.

SUPTRSBG – CASAWORKS for Families

- Evidence is required that the woman in the program is at least age 18.
- Children in the residence are age 11 or younger.
- There is evidence the woman has a principal diagnosis of substance use disorder.
- The woman has an ASAM level of 3.1 or 3.5.
- A person-centered plan must be completed upon admission to the program and reviewed at least monthly.
- A signed release of information between the county DSS and the CASAWORKS residential program must be present to communicate the person's treatment services.
- NC-TOPPS must be completed within the required timeframes.

SECTION 8

Member Rights and Responsibilities

Member Rights

Network providers must respect member rights, educate individuals on their rights, and support them in fully exercising their rights. Under the federal and state constitutions; N.C.G.S. Chapter 122C, Article 3; DMHDDSUS 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 have the right to:

- Be cared for with respect and with consideration for their dignity and privacy without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation, or gender identity
- Be told what services are available to them
- Be told where, when, and how to get the services they need from Vaya
- Be told of their options when getting services so they or their guardian can make an informed choice.
- Be told by their PCP what health issues they may have, what can be done for them, and what will likely be the result, in a way they understand. This includes additional languages.
- Get information about their health care
- Get a second opinion about their care
- Get information about Vaya, available services, Vaya network practitioners and providers, and member rights and responsibilities
- Participate with their practitioners in making decisions about their health care
- Participate in a candid discussion about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Give their approval of any treatment and any plan for their care after that plan has been fully explained to them
- Refuse care and be told what they may risk if they do
- Get a copy of their medical record and talk about it with their PCP
- Ask, if needed, that their medical record be amended or corrected
- 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
- Use the Vaya grievance or complaint process to voice complaints about Vaya or the care they receive
- Contact the NC Medicaid Ombudsman if they feel they were not treated fairly ***(for Medicaid members)***
- Request an appeal of an adverse decision by Vaya or one of our subcontractors
- Use the State Fair Hearing system ***(for Medicaid members)***
- 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
- Receive considerate and respectful care in a clean and safe environment, free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Make recommendations about Vaya's Member/Recipient Rights and Responsibilities policy

Vaya strictly prohibits retaliation by Vaya staff or network providers against any member who exercises any of the rights described in this section. Member rights may be restricted only 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 medical record.

Rights of Minors

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

Member Responsibilities

Vaya members have the responsibility to:

- Work with their PCP to protect and improve their health
- Find out how their health plan coverage works
- Listen to their PCP's advice and ask questions
- Call or go back to their PCP if they do not get better, or ask for a second opinion
- Treat health care staff with respect
- Tell us if they have problems with any health care staff by calling the Member and Recipient Service Line at 1-800-962-9003
- Keep their appointments. If they must cancel, they should call as soon as they can.
- Call their PCP when they need medical care, even if it is after hours
- Supply information (to the extent possible) that Vaya and their practitioners and providers need to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

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**
• Chiropractic services • Physician services • Non-emergency and emergency department services • Optometrist and optical services • Outpatient services • Podiatrist services	$4 per visit
Generic and brand prescriptions	$4 per prescription

There are NO copays for the following people or services:

- Members under age 21

- Services related to pregnancy, childbirth, and postpartum care, including prenatal care
- Members receiving hospice care
- Federally recognized tribal members or members receiving services through the Indian Health Service (IHS)
- Members residing in an institution who receive coverage for cost of care
- Members enrolled in Breast and Cervical Cancer Medicaid through the North Carolina Breast and Cervical Cancer Control Program (NC BCCCP)
- Members in foster care
- Behavioral health, I/DD, and TBI services
- Members enrolled in the NC Innovations and NC TBI waiver programs
- Members enrolled in Community Alternatives Programs for Children (CAP/C) and Disabled Adults (CAP/DA)
- Members enrolled in LTSS
- Family planning services
- Services covered by Medicare and Medicaid
- Adult vaccines and vaccine administration
- HIV antiretroviral (ARV) medications

A provider cannot refuse to provide covered physical health care services Vaya has authorized if a Medicaid member cannot pay at the time of service.

Vaya recipients do not have to make any payment or copay for State-funded services Vaya has authorized.

Member Grievances and Complaints

Members may file a grievance (complaint) directly with Vaya about any matter other than a Medicaid adverse benefit determination or State-funded service authorization decision, including allegations of rights violations. Vaya staff and network providers are prohibited from discouraging a member from exercising their rights, including the right to file a grievance related to the provider or Vaya or report potential fraud, waste, or abuse. Grievance submission instructions are available in Vaya's member handbooks and at vayahealth.com.

Advance Directives

Advance directives allow individuals to plan for the care they want to receive if they experience an emergency or crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. 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 based on whether they have executed an advance directive.

North Carolina has three types of formal advance directives: Living wills, health care power of attorney, and advance instructions for mental health treatment. Forms are available from the North Carolina Secretary of State's website.

Providers are responsible for educating members about advance directives and helping them create one if they desire. When a member 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 and record the reason for noncompliance in the patient's medical record.

SECTION 9

Care Management and Population Health

Tailored Care Management and Care Coordination

Vaya provides access to integrated Tailored Care Management (TCM) to eligible Medicaid members who choose to participate. Members may receive TCM from a provider organization—either an AMH+ or a CMA—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 described below. 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.

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. For more information, visit the NCDHHS TCM webpage.

Vaya offer the following additional care coordination programs:

- **Care coordination:** Medicaid members who are not eligible for, do not engage in, or opt out of TCM receive Vaya care coordination services, which are more limited than TCM but include coordination of services and oversight of care transitions.
- **Complex care coordination:** Medicaid Direct members who are not eligible for TCM and have a behavioral health transitional care need receive Vaya complex care coordination to prevent unplanned or unnecessary readmissions, ED visits, or other adverse outcomes. Complex care coordination is also available to members with identified special health care needs to ensure appropriate service referral and coordination.
- **1915(i) care coordination:** Members who are not participating in TCM and receive 1915(i) services receive Vaya care coordination.
- **State-funded care management:** Vaya Care Managers coordinate and provide referrals, information, and help recipients obtain and maintain State-funded services.

Referrals for Care Management

Vaya accepts external referrals for care management/care coordination 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 NCDHHS Raise Your Hand process. Vaya expedites responses to referrals from medical providers, primary care case management (PCCM) Care Managers, and state and local agencies, including DSS and North Carolina Division of Juvenile Justice and Delinquency Prevention (DJJ) offices. To make a referral, call the Member and Recipient Service Line at 1-800-962-9003.

TCM Provider Requirements

The NCDHHS TCM Provider Manual contains additional information on TCM requirements, including the following:

- TCM staffing requirements
- Use of clinical consultants
- Care coordination
- Enrollment, referral, and assignment of TCM
- Outreach and engagement
- Coordination with county child welfare workers
- Care management comprehensive assessment
- Care plan development
- Transitional care management
- Response times for inquiries
- Care team formation
- Ongoing care management
- Contact requirements
- Coordination with other care management programs
- 1915(i) care coordination
- Innovations Waiver care coordination
- Members participating in TCL
- Diversion and in-reach

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

TCM providers must identify members who are not eligible for TCL and are at risk of entry into an institutional setting such as an ICF/IID, psychiatric hospital, or PRTF and perform diversion activities as described in the TCM Provider Manual.

Network Provider Coordination with TCM

Network providers must fully cooperate with organizations providing TCM and integrated care activities. As a provider of services for members receiving TCM, and to the degree the member/LRP agrees, you should plan to collaborate with the Care Manager in the following activities:

- 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
- Participate in completing a care management comprehensive assessment at least every 12 months
- Engage in care plan and crisis plan development and ongoing care team meetings
- Continuously monitor 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
- Conduct medication management, facilitate regular medication reconciliation by the appropriate care team member, and support medication adherence
- Support the member's adherence to prescribed treatment regimens and wellness activities

- Coordinate 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
- Coordinate with other care management supports for members dually eligible for Medicare and Medicaid
- Ensure members have annual physical exams or well-child visits based on the appropriate age-related frequency
- Communicate and consult 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)
- Follow up on referrals
- Coordinate with Vaya on institutional transition activities
- 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 CCPs 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
- Work with Vaya's transition team, TCM provider, PCPs, and other Vaya network 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
- 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, DMHDDSUS 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.

Referrals to State Developmental Centers

Any individual requesting an application for a State Developmental Center (SDC) must be coordinated with Vaya, as we are responsible for ensuring all North Carolina Division of State-Operated Healthcare Facilities (DSOHF) admission criteria and protocols are met. **SDCs are not considered long-term or lifetime residential placements, and individuals must be reviewed quarterly for discharge consideration.** Providers and Care Managers must help members receive services in the least restrictive setting. Each member accepted for admission to a SDC will be accepted only under a memorandum of agreement (MOA) for three to six months. Vaya will ensure timely execution of the MOA with the member's guardian regarding their discharge plan and begin work on the discharge plan on day one of admission.

Provider staff or the assigned Care Manager should staff the case with an internal clinical team first. If the provider's clinical team agrees a referral to an SDC is warranted, the provider's clinical/medical team completes Vaya's TCM External

Clinical Consultation Request form on the Forms page of our Provider Central website and submits the form to SNStaffing@vayahealth.com.

Consultations are held via Microsoft Teams, with the option for participation online or by telephone. Vaya will send an invitation once the consultation has been scheduled. A representative of the provider organizations' clinical staff or medical team is required to attend.

Vaya's I/DD In-Reach and Transition Manager 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. The Vaya I/DD Transition Coordinator follows individuals accepted into an SDC through discharge.

Duplicative Services and Other Care Management Programs

Per NCDHHS, certain services are duplicative of TCM and cannot be provided at the same time. The list below reflects the services defined as duplicative. Although TCM serves as the predominant care management model for members, Vaya recognizes additional care management options for specific populations. These include Local Health Departments, pregnancy management programs, HIV case management providers, 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.

Services Duplicative of TCM

- ACT
- Child ACT
- Critical Time Intervention
- ICF/IID
- Primary care case management (PCCM), such as Community Care of North Carolina (CCNC) or the EBCI Tribal Option
- High-fidelity Wraparound (HFW)
- EBCI Tribal Option
- Program of All-Inclusive Care for the Elderly (PACE)
- Care Management for At-Risk Children (CMARC)
- Stays of 90 or more days in a Skilled Nursing Facility
- CAP/C services
- CAP/DA services

Note: Incarcerated individuals cannot obtain TCM, given their NC Medicaid coverage is suspended or terminated. Upon release, individuals may re-enroll in TCM if they remain eligible or become newly eligible.

Other Care Management Programs

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. When a member is receiving a service other than those listed above that has potential for duplication with TCM, the Care Manager and 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. Providers delivering services duplicative of care management must notify Vaya within 45 days of a member transitioning into or out of the service.

Local Health Department Programs

Local Health Department care management programs include CMARC and Care Management for High-Risk Pregnancies (CMHRP). See the TCM Provider Manual for details.

Pregnancy Management Program (PMP)

Vaya receives standardized screening tool results from PMP providers. When a PMP provider, the member, family, or another entity refers a member with a high-risk pregnancy to Vaya, we arrange member enrollment into CMHRP and inform 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 specific immediate member needs. HIV case management includes assessment, care planning, resource development, services coordination, monitoring, reassessment, and discharge.

HFW

HFW providers must facilitate timely communication across the care team. If a member meets the HFW eligibility criteria and elects to participate, the member will transition from TCM to HFW services. The assigned TCM provider facilitates a warm handoff to the HFW team, at which time Vaya disenrolls 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 NCDHHS 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 that delivered HFW if that provider is certified as a CMA and has capacity to serve the member.

Children Developmental Services

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:

- Incorporate the child's Individualized Family Service Plan (IFSP) into the person-centered plan or care plan;
- Update the plan on an ongoing basis to reflect any changes to the IFSP;
- Request that the CDSA service coordinator participate in the child's care team meetings, upon consent of the parent/LRP; and
- 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.

PCCM

Members who are not receiving TCM may obtain both care management through the PCCM vendor and care coordination through Vaya. Vaya is the lead care coordination entity for members with a behavioral health transitional care need; for other members, the PCCM vendor takes the lead in coordinating the member's care.

Members may receive PCCM services from 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.

EBCI Tribal Option and Care Management

Vaya works closely with the EBCI through our Tribal Engagement Strategy, which includes culturally sensitive care management and coordination for federally recognized Tribal members and IHS-eligible individuals. At the request of NCDHHS, and in consultation with the EBCI, Vaya performs certain functions for federally recognized Tribal members and IHS-eligible individuals.

The EBCI Tribal Option is a PCCM for federally recognized Tribal members and IHS-eligible individuals, primarily in Cherokee, Graham, Haywood, Jackson and Swain counties. Vaya, in collaboration with EBCI Tribal Option, manages behavioral health, I/DD, and TBI services for EBCI Tribal Option members through our Medicaid Direct PIHP. For members enrolled in the EBCI Tribal Option, the EBCI Tribal Option Care Manager is the primary Care Manager and collaborates with Vaya to avoid duplication of coordination services. EBCI Tribal Option PCCM is considered duplicative of TCM, and a member may not receive both at the same time. EBCI Tribal Option PCCM includes all features available through TCM.

TCM-eligible federally recognized Tribal members and IHS-eligible individuals may enroll in the EBCI Tribal Option or the Vaya Tailored Plan or remain in Medicaid Direct. Vaya serves as the primary care management provider for Tribal members enrolled in the Tailored Plan. The Vaya Care Manager coordinates with Cherokee Indian Hospital Authority (CIHA) medical home Care Managers for members held in common. Federally recognized Tribal members and IHS-eligible individuals in Medicaid Direct may receive behavioral health, I/DD, and TBI services through Vaya, an IHS provider, or a federally recognized Tribal provider.

Transitions to Community Living (TCL)

Vaya administers North Carolina's 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.

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 live in leased housing, learn everyday skills, take part in community activities, and develop lasting relationships. Participants receive health care services, employment assistance, and help becoming part of the community.

Care managers delivering TCM to a TCL participant participate in meetings with Vaya TCL staff during a participant's transition to Supportive Housing and assist in the care management for the TCL population, but established TCL-specific functions remain the responsibility of Vaya TCL staff. Additional guidance for providing TCM to the TCL population is included in the TCM Provider Manual.

Referrals to TCL

Individuals who are eligible for TCL must meet specific criteria for referral through the Referral Screening Verification Process (RSVP). If you are working with an individual you would like to be considered for TCL, submit a referral 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 adult care home (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

Vaya's RSVP/Diversion Team screens referrals within 30-45 days.

Prevention and Population Health Programs

Vaya takes a population-based approach to improving overall member health 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 eligible Medicaid members, using multiple sources and pathways to identify individuals who are likely to benefit.

Alignment with Department Priorities

Vaya's prevention and population health programs align with the NCDHHS larger public health goals and Quality Strategy. NCDHHS-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 (e.g., interventions that will improve functional status and quality of life among members with behavioral health issues, I/DD, or TBI)

For more information about available programs, visit vayahealth.com.

Medicaid Value-Added Services (VAS)

VAS, called Vaya Total Care Perks, offer extra support for eligible Vaya Total Care members. Vaya offers the following VAS:

- Vaccine incentives (influenza and COVID-19)
- Home-delivered meals after a qualifying hospital stay
- WW (WeightWatchers) program
- Breast pump and lactation support

- GED support
- Non-medical transportation
- Safety equipment to support independent living

SECTION 10

Quality Management

Continuous Quality Improvement and Outcomes Requirements

Vaya collaborates with network providers to maintain an innovative, integrated, and person-centered system of care. The Quality Management and Improvement Program) focuses on health outcomes and aligns with North Carolina's Medicaid Managed Care Quality Strategy. Vaya complies with our contracts with NCDHHS, using data-driven processes to improve health outcomes. Performance Improvement Projects (PIPs) and Quality Improvement Activities (QIAs) address clinical care quality, service quality, and member experience.

The Quality Improvement Committee (QIC) includes Vaya staff, members, and network providers. The Board's Regulatory Compliance and Quality Committee oversees QIC, and reviews reports for quality improvement.

Vaya's Provider Network Operations and Quality Management (QM) departments support providers in implementing interventions in the Provider Support Plan. The Provider Support Plan aims to improve care at all provider levels. Network providers must develop processes to continually self-assess services, member outcomes, and operations. In addition, providers must comply with all federal and state quality assurance and performance improvement standards, including, but not limited to:

1. Establish a quality committee
2. Maintain client rights committee minutes
3. Develop an annual Quality Improvement Plan
4. Participate in PIP/QIA activities
5. Report incidents
6. Cooperate with grievance/complaint, monitoring, and program integrity activities
7. Participate in satisfaction surveys

Member Satisfaction Surveys

Surveys provide Vaya's Quality Management Improvement Program (QMIP) with insights into member needs, preferences, and experiences. In partnership with NCDHHS, Vaya administers various member surveys, including the Consumer Assessment of Healthcare Provider Systems (CAHPS), Perception of Care, and National Core Indicators (NCI) surveys. These surveys measure satisfaction with factors such as provider performance, quality of care, cost of services, availability of treatments, and ease of access to care. Network providers are required to participate in the survey process and assist with the dissemination and completion of member surveys. Vaya partners with providers to use survey results to identify needed services, health outcomes, training needs, and quality improvement initiatives.

Clinical Studies

Vaya collaborates with network providers to conduct clinical studies that target quality improvement goals, including enhanced population health outcomes, improved care and member experience, increased provider satisfaction, and reduced costs for better value. All services performed must be medically necessary, non-experimental, and adhere to the

generally accepted standards of medical practice in North Carolina. Network providers are required to participate in clinical studies as requested or as appropriate.

Performance Improvement Procedures

Monitoring

Vaya maintains a data-driven provider monitoring and performance improvement program to ensure services billed meet quality and regulatory standards, promote member safety, and maintain provider accountability. Activities may entail announced or unannounced onsite visits and desk reviews, including the following:

- Clinical quality reviews
- Complaint/grievance investigations
- Compliance and policy reviews to evaluate provider compliance with Controlling Authority
- Focused provider monitoring
- Innovations Waiver-specific monitoring, including Home Modifications and Individual and Family Directed Services (IFDS), which includes Employer of Record (EOR) and Agency with Choice
- Monitoring of fidelity for specific services, including, but not limited to, services provided under the TCL program, such as ACT
- Monitoring of eligibility criteria for State-funded services
- Service-specific reviews
- Quality of care and member health and safety
- TCM performance reviews
- Trend-related monitoring based on any of the following: significant indicators and/or reported trends that may impact quality services; evaluation of compliance requirements for potential corrective measures; and trends identified through service utilization, costs, and needs of the network
- Federal and state block grant review

Vaya notifies providers in writing prior to monitoring activities, except for health and safety reviews and investigations, when Vaya provides written notification onsite. Vaya provides a copy of the review tool prior to monitoring. Providers are required to give Vaya copies of requested documentation and must present all information for consideration by the conclusion of the monitoring activity. Vaya conducts opening and exit summary conferences for applicable reviews.

The opening conference includes:

- Introductions and explanation of roles of each Vaya staff present
- General purpose of the review or investigation
- Expected timeframe for completion of the review or investigation
- Format and timeline for informing the provider of the findings and outcome

The exit conference includes:

- Summary of preliminary results
- Preliminary findings, identification of strengths and required follow-up for each area where non-compliance or deficiencies were noted
- Health and safety concerns requiring immediate follow-up or referral to external agencies
- Signing of the Monitoring Attestation Form, which includes a list of all documents requested in addition to items listed in the initial letter, the due date for submission, and the provider's primary contact person

Vaya notifies providers of the results of monitoring activities in writing via email or certified mail. Review findings may result in technical assistance, a Plan of Correction (POC), self-audit, referral for overpayment assessment, or adverse actions, and may trigger reports to:

- Vaya Special Investigations Unit (SIU) (alleged fraud, waste, or abuse; see Section 11, Program Integrity)
- DHSR or out-of-state licensure bodies
- NC Medicaid, DMHDDSUS, or other LME/MCOs
- CMS (Medicare fraud, waste, or abuse)
- County DSS (abuse, neglect, or exploitation)
- Provider/practitioner licensure and/or accrediting bodies
- Law enforcement

Additional quality and performance improvement activities include technical assistance, written communication bulletins, training, education, and development of supportive and collaborative plans to address identified gaps and trends.

NOTE: Vaya reserves the right to issue an educational letter, POC, self-audit overpayment, or adverse action, up to and including termination of your contract(s) with Vaya, in response to any findings from provider monitoring activities. We are not required to issue prior notice or provide the opportunity to complete a POC prior to issuing an adverse action. Following a review, Vaya reserves the right to make additional referrals to external agencies without prior notification to providers. Failure to respond to written or verbal request, or complete requested monitoring or performance improvement activities within the given timeframe, may result in adverse action.

Adverse Actions

Vaya may issue adverse actions for non-compliance with federal and state laws, regulations, policies, this manual, your contract with Vaya, or any other payor program requirements. If NCDHHS notifies Vaya of a provider's termination from the NC Medicaid program, we remove the provider from our claims payment system, terminate their contract within one business day, and deny payment for services after the Medicaid termination date. Vaya bases adverse actions decisions on fair, impartial, and consistent factors.

Administrative actions do not change a provider's status in the Vaya network and may include:

- Moratorium on expansion: temporarily prohibits adding sites or services or from responding to any Vaya procurement activity
- Payment suspension: suspends payments for up to six months, unless required longer by law
- Probation: increases monitoring for up to one year
- POC: addresses non-compliance issues through a written plan

Sanctions change a provider's status in the Vaya network and may include:

- Contract suspension: prohibits participation in the network for a period, transitioning members to other providers (includes suspension to ensure health and safety)
- Exclusion: terminates the contract and prohibits re-application
- Limitations to or suspension of referrals: restricts new or additional referrals
- Site/service termination: terminates specific sites or services
- Full contract termination: terminates the contract for all sites and services

Automatic termination involves an immediate contract suspension or termination when:

- DHSR issues a penalty against the provider's license
- CMS issues an immediate jeopardy finding

- Accreditation or license is suspended or revoked
- NCDHHS or another state agency suspends or terminates the provider's participation in Medicaid
- Another LME/MCO suspends or terminates the provider's participation
- CMS suspends or terminates the provider's Medicare participation
- NCDHHS issues a payment suspension or revokes the provider's ability to receive funding

Providers receive written notice of adverse actions, including the nature, effective date, basis for the decision, and appeal process (see Section 12, Provider Dispute Resolution, for information on appeals). Vaya sends initial notifications via email, followed by trackable mail if not acknowledged within one business day. 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.

Vaya reports denied provider applications, terminated contracts, and actions taken for program integrity reasons to NC Medicaid monthly and shares this information with other LME/MCOs and relevant accrediting bodies or licensing boards.

DME

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. Prior approval is required before delivery and prescribers must document medical necessity. Providers must keep detailed records of items and services provided.

Vaya's Quality Management Department and Special Investigations Unit monitor DME providers for compliance and potential misuse of funds. For additional information, refer to the NCDHHS DME webpage or the CMS Final Rule at 42 CFR § 440.70.

Incident Reporting

Vaya monitors incidents involving Category A and B providers of behavioral health, I/DD, and TBI services. 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 and that is likely to lead to adverse effects to the member/recipient. Incidents are classified into three categories based on severity (Levels I, II, and III). Network providers must:

- Report all Level II and III incidents in the state's Incident Response Improvement System (IRIS) within the required timeline.
- Notify Vaya by emailing IncidentReport@vayahealth.com of a member's death if seen within 90 days prior and initiate a formal review within 24 hours of the incident.
- Document and maintain records of all Level I incidents. Vaya has approval from NCDHHS to waive the requirement for providers to submit monthly quarterly incident reports (Form QM 11) to Vaya through June 30, 2028. Providers must make Level I incident reports available upon request.

Out-of-state providers without IRIS access must submit paper reports via fax to NCDHHS at 984-777-9864 and Vaya at 828-398-4407.

Providers must have an internal quality management process to review, investigate, and follow up on incidents, including:

- Periodic reviews for trends
- Strategies to reduce/eliminate trends/patterns
- Documentation of improvement efforts
- Adherence to reporting requirements

Vaya reviews and tracks all incident reports, ensuring completeness and appropriate interventions. Timely report submission and responsiveness to report submissions by Vaya staff and NCDHHS is essential to ensuring that adverse events are addressed quickly and analyzed to prevent future occurrences. Non-compliance may result in a POC or other adverse action.

Vaya's Critical Incident Review Committee (CIRC) reviews all Level III incidents and may request additional documentation. Providers are required to cooperate with this process and submit records as requested. 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 further investigation.

For more information, visit the IRIS website and the NCDHHS IRIS webpage.

SECTION 11

Program Integrity and Compliance

Provider Program Integrity Requirements

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. We comply with all federal and state laws, program integrity or audit requirements, investigations, findings, or corrective action plans related to provider payments. All network providers must monitor for potential fraud, waste, and abuse as defined below and take immediate action to address reports or suspicion:

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste** is the overuse of services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program. Most waste does not involve a violation of law.
- **Abuse** is provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to a health care benefit 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 health care benefit program.

Examples of Medicaid fraud include billing for services not rendered, that are unnecessary, or that lack documentation; billing for inflated hours or for more expensive procedures than were performed; double billing; medical identity theft; upcoding: unbundling; falsifying credentials: substituting generic drugs; kickbacks; and false cost reports.

How to Report Suspected Fraud, Waste, and Abuse

You are required to establish a system for employees, contractors, and individuals receiving services to report potential fraud, waste, or abuse and ensure they are aware of the following reporting mechanisms:

- 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 NCDHHS Customer Service Center at 1-800-662-7030.
- Call the U.S. Office of Inspector General's fraud hotline at 1-800-HHS-TIPS (1-800-447-8477).

Reporters may remain anonymous or leave their name, but detailed information will help us with our investigation. Network providers may not intimidate or impose any form of retribution against an employee, agent, or member who reports suspected violations to Vaya in good faith.

Compliance with Other Federal and State Requirements

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, as amended from time to time:

- 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
- NC Medicaid Waivers authorized by CMS pursuant to sections 1115(a), 1915(b), 1915(c), and/or 1915(i) 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, 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 and their immediate family members)
- 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 90, 108A, 108D, 122C, 131D, and 131E
- All federal and state member/recipient rights and confidentiality laws, rules, and regulations, including, but not limited to:
    - 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
    - N.C.G.S. §§ 122C-52 through 56
    - The North Carolina Identity Theft Protection Act, N.C.G.S. §§ 75-61 et seq.
    - DMHDDSUS Client Rights Rules in Community Mental Health, Developmental Disabilities, and Substance Abuse Services, APSM 95-2
    - DMHDDSUS Confidentiality Rules, APSM 45-1
- Medical and/or CCPs 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
- DMHDDSUS Rules for MH/DD/SA Facilities and Services, published as APSM 30-1 and codified at Title 10A of the North Carolina Administrative Code
- DMHDDSUS Records Management and Documentation Manual, APSM 45-2 (RMDM)
- The Record Retention and Disposition Schedule for DMHDDSUS 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 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

False Claims Act

A federal statute originally enacted in 1863 in response to defense contractor fraud during the American Civil War, the False Claims Act (FCA) imposes penalties for filing a false or fraudulent claim to a government agency. Under the FCA, any person who knowingly submits, or causes to submit, false claims to the government is liable for three times the government's damages, plus a penalty, for each false claim. **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.** 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 FCA, state false claims laws, and the rights and protections afforded whistleblowers under the FCA and its state counterparts.

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. 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. As of February 2025, FCA civil penalties increased to between $14,308 and $28,619 per claim, plus three times the amount of damages the federal government sustains because of the false claim.

There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. The OIG also may impose administrative civil monetary penalties for false or fraudulent claims. 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.

Health Information Technology and Security

As a network provider and covered entity under HIPAA, you are required to comply with the HIPAA Privacy Rule, 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) and requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards. 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 business associates to provide notification following a breach of unsecured PHI. For more information, refer to the U.S. HHS Summary of the HIPAA Security Rule webpage, the Breach Notification Rule webpage, and healthit.gov.

Electronic Visit Verification

Section 1903(l) of the Social Security Act requires use of an electronic visit verification (EVV) system for PCS and Home Health Services that require an in-home visit by a provider for states participating in the Medicaid program. In addition to NC Medicaid State Plan services, Innovations Waiver CLS and Supported Living services are subject to the EVV requirements Vaya uses HHAeXchange as our EVV vendor. Visit our Electronic Visit Verification webpage for more information.

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

Provider 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 CFR § 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. At a minimum, the plan should include the following elements:

- 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 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, refer to the U.S. HHS OIG Compliance Resource Portal.

Investigations and Self-audits

Vaya's Special Investigation Unit (SIU) investigates 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 North Carolina 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.

The SIU may conduct 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. Providers must cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by Vaya and/or NCDHHS.

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 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 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.

We will notify you in writing if the SIU identifies an overpayment based on abuse, waste, overutilization, or non-compliance with your contract. Notifications include the amount owed, process for dispute resolution, and deadline and mechanism for repayment, as well as the process for requesting a payment plan or appeal within 30 days of the notice. 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.

Action by Vaya does not preclude NCDHHS, including the DMHDDSUS Financial Audit and Program Integrity teams or MID, from conducting an audit or accepting a self-disclosure from a provider, even if Vaya has conducted an audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.

Prepayment Review

The SIU may utilize the prepayment pending of claims while an investigation of billing anomalies is investigated or as a corrective action measure. Vaya's Regulatory Compliance Committee (RCC) must approve prepayment review, and we must notify the provider in writing. The process automatically pends the provider's claims so that a clinical medical record review can ensure documentation supports claims billed prior to payment. Claims received without medical records will be denied, and Vaya will instruct the provider to resubmit the claim with records. When the review is complete, Vaya will process the claim according to clinical review recommendations. We will you send a monthly prepayment pended claim review status letter that includes a description of review findings.

To ensure compliance with NCDHHS billing guidance, the SIU may conduct additional reviews and/or audits, including high-cost and high-dollar, due to their financial impact and the potential risk of fraud, waste, or abuse. These reviews

verify compliance with elements such as medical necessity, prior authorization, appropriate coding, and adherence to Medicaid policies.

The SIU monitors billing accuracy while the provider is on prepayment review. When a provider maintains a billing accuracy rate of a minimum of 70% clean claims for a minimum of three consecutive months within six months of being placed on the prepayment review, the SIU may remove the provider from prepayment review with the RCC's approval. During the prepayment review period, the number of claims submitted per month must be no less than 50% of the provider's average monthly submission of Medicaid claims for the three-month period prior to their placement on prepayment review. Vaya may take additional actions, up to and including contract termination, against providers who are noncompliant with the prepayment review.

SECTION 12

Grievances and Appeals

Vaya offers network and OON providers grievance and appeal rights that are distinct from those offered to members. Our timely, fair, and impartial system allows providers to raise concerns through the grievance process or dispute certain actions or decisions taken by Vaya, including claim denials, through the appeal process.

Grievances Against Providers

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 upon admission to treatment and upon request. Any unresolved grievances or violations of member 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: 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.-5 p.m., Monday-Friday, except for state holidays)
- **Website:** medicaid.ncdhhs.gov/about-nc-medicaid/nc-medicaid-ombudsman

NCDHHS Office of Privacy and Security:

- **Phone:** 919-855-3000
- **Fax:** 919-733-1524
- **Online reporting:** 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:** ncdhhs.gov/divisions/aging/long-term-care-ombudsman
- **Mailing address:** 2101 Mail Service Center, Raleigh, North Carolina 27699-2101

North Carolina 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. HHS 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 also may file a grievance 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 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)

Retaliation by network providers or Vaya against individuals who report concerns or file grievances is strictly prohibited.

If we receive a grievance 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 Chief Medical Officer will be notified and take immediate action as determined necessary. You must keep documentation on all grievances 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 without your input, and you may be referred for follow-up and potential sanction.

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.

Vaya makes every effort to resolve member grievances within 30 days. Under federal law, we have up to 90 days to resolve a Medicaid grievance. Individuals who file a grievance 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

Provider Grievances

A provider grievance (complaint) is an expression of dissatisfaction, either orally or in writing, by or on behalf of a provider over any aspects of the operations, activities, or behavior of Vaya, the NEMT broker, pharmacy benefit manager (PBM) subcontractor, vision services vendor, or another delegated subcontractor. Provider grievances are distinct from provider appeals (described below).

Vaya encourages providers to address concerns informally through our Provider Network Operations or Claims departments, but this step is not required. Providers may file a formal grievance at any time as follows:

- Electronically using the Vaya EthicsPoint portal (allows for anonymous reporting)
- Orally to any Vaya employee, who will file the grievance in EthicsPoint on the provider's 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 GRIT at 1-800-893-6246, ext. 1600
- By emailing ResolutionTeam@vayahealth.com
- Via hand-delivery, fax, email, or mail to any Vaya administrative office location or staff member

Vaya resolves provider grievances within 30 days from receipt of the grievance, unless an extension is warranted, in which case, Vaya has 90 days for resolution. Vaya sends the provider a Notice of Resolution that identifies the efforts made to resolve the grievance, Vaya's findings, and any proposed resolution.

Provider Appeals

Vaya maintains a formal appeals process available to any provider who wishes to initiate it in response to an qualifying administrative action or sanction against the provider. The provider appeals process applies to provider disputes, not to member appeals of an adverse benefit determination filed by a provider as the member's personal representative. For information on member appeals, see Section 2, Clinical Practice Standards and UM Program.

The provider appeals process features separate tracks for administrative actions, claims denials, and sanctions:

- An **administrative action** is a decision, action, or inaction taken by Vaya against a network provider that does not result in a change to the provider's status within the Vaya network or against an OON provider.
- A **claim denial** (a type of administrative action) is a request for payment that is received as clean and processed by Vaya but that does not meet all criteria required 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.
- A **sanction** is a decision, action, or inaction Vaya takes against a provider, or its owners, managing employees, or practitioners, based on professional competence or conduct or resulting in a change to the network provider's status within the Vaya network.

Providers may appeal actions and decisions according to the three tracks below:

Appeal Track	Network Provider	OON Provider
Administrative Actions: Claim Denials	Denial of claims	Denial of claims
Administrative Actions: Others	• Finding of or recovery of overpayment • Withhold or suspension of a payment • Corrective action by Vaya	• Disputes regarding an OON payment arrangement, such as a single-case agreement • Finding of waste or abuse by Vaya • Finding of or recovery of overpayment by Vaya • Declination to contract as a network provider
Sanctions	• Partial or full contract or practitioner termination • Suspension of referrals, admissions, or contract • Determination to de-certify by AMH+ or CMA	N/A

For any disputes that do not fall into a category listed above, Vaya will review the request and determine whether the dispute is valid and timely. Any action, decision, or inaction for prepayment reviews, closed network denial decisions, and NCDHHS-initiated suspensions, terminations, or other actions are not appealable to Vaya. If the dispute is valid and timely, or if an extension to appeal is granted, an appeal panel review will occur on the same timeframe as for an equivalent type of provider appeals as described in the next section (Appeals Process Timeline). If the appeal is invalid or untimely, you will receive a written notification.

Appeal Process Timeframes

Providers must exhaust Vaya's internal appeal process before seeking recourse under any other process permitted by contract or law. Each appeals 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.

All appeals undergo at least one level of panel review. Providers appealing a claim denial or sanction may request a second-level review if they are unsatisfied with the Level 1 decision. The table below details required timeframes for each appeal track:

Track	Request Due	Level	Format	Review Timeframe*	Final Decision Timeframe*
Administrative Actions: Claim Denials	5 p.m. Eastern time on the 30th calendar day after the issuance of RA/Notice of Denial	Level 1	Desk	14 calendar days of receipt of complete appeal request	30 calendar days of receipt of complete appeal request
	30 days of the Level 1 decision notice date	Level 2	Video conference or desk	14 calendar days of receipt of complete appeal request	30 calendar days of receipt of complete appeal request
Administrative Actions: Others	5 p.m. Eastern time on the 30th calendar day after the date of the written Notice of Administrative Action	Single-level	In person, video conference, or desk	14 calendar days of receipt of complete appeal request	30 calendar days of receipt of complete appeal request
Sanctions	5 p.m. Eastern time on the 30th calendar day after the date of the written Notice of Sanction	Level 1	In person, video conference, or desk	14 calendar days of receipt of complete appeal request	30 calendar days of receipt of complete appeal request
	10 days of the Level 1 decision notice date	Level 2	In person, video conference, or desk	14 calendar days of receipt of complete appeal request	30 calendar days of receipt of complete appeal request

**The timeframe indicated applies unless there is an extenuating circumstance as described in the Appeals Panel Meeting section below.*

If the due date falls on a day the Vaya administrative office is closed, the notice will be issued the next day the office is open.

Reimbursement will continue during the appeals process **unless** a payment suspension is issued for any reason, including due to a credible allegation of fraud or abuse or if Vaya believes continued reimbursement is likely to increase any overpayment amount due.

Appeal Request Submission

Network providers and OON providers with access to Vaya's Provider Portal must request an appeal via the portal. OON providers without portal access may submit the Level 1 Request for Appeal Review of Claim Denial Form, available on Vaya's Provider Central website, or request the form by emailing claims.appeals@vayahealth.com. To request forms for other types of appeals, email provider.appeals@vayahealth.com. All documentation you wish to be considered must be submitted electronically with the request form.

We will consider our action final if we do not receive a fully completed appeals request by 5 p.m. on the 30th calendar day following mailing of the notice. It is your responsibility to ensure delivery and provide proof of submission, if needed. If you are unable to submit a timely appeal request for good cause shown, Vaya will extend the submission timeframe to 60 days.

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

Appeals Panel Meeting

The panel meeting will be scheduled to occur no later than 14 calendar days after receipt of a valid and complete appeal request, unless there are documented extenuating circumstances for the provider or Vaya. If the review deadline falls on a day Vaya's administrative office is closed, the meeting may be scheduled the next business day.

Once scheduled, panel meetings are not 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. Even 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.

Appeal reviews for sanctions include one panel member who is a clinical peer selected from the Vaya provider 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).

For desk reviews, the panel reviews documentation, deliberates, and reaches a decision without hearing presentations from Vaya staff or the provider. The panel may contact Vaya staff, legal counsel, or providers to ask specific questions to reach a decision. A designated staff person takes minutes for the meeting.
For in-person and video conferencing reviews, each party receives an equal opportunity to present relevant evidence to the panel. Panel meetings are informal and non-adversarial. Witnesses are not sworn, and cross-examination is not permitted. The meeting may not be recorded by audio or video. The panel will deliberate after the hearing, weigh the evidence, and make a decision. Determinations to uphold, revise, or overturn the decision or pend for more information must be reached by a two-thirds majority vote. Vaya's Executive Leadership Team (ELT) is authorized to overturn or revise the decision of any Vaya appeals panel.

A Vaya attorney is usually present during panel hearing held in person or via video conferencing and during panel deliberations, except for claim denial appeals, to address legal questions. You are welcome to include your attorney at any point in the appeal process.

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. For disputes that can be and are appealed to second level, the date of the decision letter from the second level is the date of the final decision by Vaya.

Confidentiality of Panel Meetings

Vaya is a government entity subject to the North Carolina Public Records Act, N.C.G.S. Chapter 132. While there are some exceptions (e.g., 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 impacted by the dispute.

Medicaid Provider Ombudsman Service

The NC Medicaid Provider Ombudsman represents 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 1-866-304-7062 or email Medicaid.ProviderOmbudsman@dhhs.nc.gov.

SECTION 13

Claims, Billing, and Payments

This section provides a high-level overview of the provider billing and reimbursement process. Vaya adheres to billing requirements outlined in the NCDHHS Health Plan Billing Guide and NC Medicaid CCPs. For more information, contact the Vaya Claims Department at 1-800-893-6246 (ext. 2455 for behavioral health; ext. 2456 for physical health), or submit the Provider Service Desk Request Form.

Claims Processing Requirements

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

- **Enrollment and member ID:** The individual must be eligible for and enrolled in a Vaya health plan for a claim to be processed. The member ID number identifies the individual receiving the service and is assigned by Vaya's Conduent HSP claims system. All claims submitted with incorrect member ID numbers, or for members whose enrollment is no longer active, will be denied.
- **Medical necessity:** All services paid with public funds must meet documented medical necessity criteria.
- **Prior authorization:** Vaya must authorize certain services prior to service delivery and claims submission. Vaya's claims adjudication system verifies 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. However, the IHS is the payor of last resort for individuals defined as eligible for "contract health services" under CFR 42 Part 136. Likewise, in instances where a member is also accessing State-funded services, State-funded services are the payor of last resort.
- **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. 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 RMDM. Restrictions affect payment for services delivered to people admitted to facilities with more than 16 beds that are classified as IMDs. This may include some state facilities, private hospitals, ACHs, and Family Care Homes. 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 Details

- **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 "passthrough" period. Passthrough limits are applied per member, not per provider. Once the passthrough limit is reached for an individual, all claims submitted without an authorization will be denied.

Claims Submission

Network providers (or billing agents or clearinghouses) must submit all claims via 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:

- Non-institutional providers or suppliers must be submitted using the American National Standards Institute (ANSI) 837P (professional) format or the electronic CMS 1500 form if billing through the portal.
- Institutional providers must bill for services using the ANSI 837I (institutional) format or the electronic UB04 form if billing through the portal.

OON Paper Claims

Vaya accepts paper claims only from OON hospitals or physician groups that submit claims for emergency and post-stabilization services or during continuity of care periods as defined by NCDHHS. These providers are required to mail an accurate CMS 1500 or UB04 billing form with the correct data elements to Vaya Health, Attn: Claims, 200 Ridgefield Court, Suite 218, Asheville, NC 28806.

Submission Timeframes

Claims for Medicaid services must be submitted within 365 days of the date of service or discharge, unless otherwise specified in your contract. Claims for State-funded services must be submitted within 90 days of the date of service or discharge.

Vaya Medicaid is payor of last resort. **Claims in which Vaya is the payor of last resort must be submitted within 180 days of the date you receive a remittance from a first- or second-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. Vaya encourages network providers to produce routine billings on a weekly or bimonthly schedule in conjunction with our Checkwrite Schedule.

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 uses upfront edits (SNIP Levels 1 through 7) as well as NCTracks validations to ensure clean claims receipt. If claims do not meet the edits or validation, these claims may reject prior to entering Vaya's claims processing system and be returned to the provider. Vaya will send the provider a letter describing the reason for the rejection.

Vaya uses National Correct Coding Initiative (NCCI) edits and Medically Unlikely Edits (MUE) during adjudication to validate claims to prevent improper payment. These edits, managed by CMS, are available on the CMS Medicaid NCCI webpage.

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 RA).

Sites and Services

Approved provider sites and services are listed in the Provider Portal. Upon request, the Vaya Contracts Team will produce a report that identifies the sites and services associated with your contract. It is your responsibility to verify the portal information is accurate. You may bill only for sites and services listed in the portal, or Vaya will deny reimbursement as a non-contracted service.

Reimbursement is driven by the fee schedule associated to the taxonomy on the provider claim and profile. Providers must be enrolled in NC Medicaid and with NC Tracks before billing claims to Vaya. We cannot accept claims from providers or for service locations that are not in NCTracks.

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: 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 DSM-5-TR.

Rates

Vaya reimburses 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 North Carolina General Assembly, NC Medicaid, or DMHDDSUS. Providers may 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 CFR §§ 438.3(k) and 438.230(c)(1)-(2).

For more information, see the Rate and Checkwrite Schedules page of our Provider Central website.

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.

RAs 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 the Claims Department at 1-800-893-6246, ext. 2455 (physical health) or ext. 2456 (behavioral health) or submit a Provider ServiceDesk Request Form. Section 12 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 North Carolina 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 and federal law as follows:

- **Medical claims:** Within 18 calendar days after receiving a clean claim or invoice from a provider for a medical claim, Vaya either approves or denies payment or determines additional information is required for approval or denial. Vaya pays approved medical claims 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.
- **Pharmacy claims:** Within 14 calendar days after receiving a clean claim or invoice from a provider for a pharmacy claim, Vaya either approves or denies payment or determines additional information is required for approval or

denial. Vaya pays approved pharmacy claims 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.

Interest and Penalty Provisions for Late or Underpayment

If Vaya fails to pay any approved claim to a provider 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. 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. Vaya does not use funds allocated to pay for health care services to pay interest to a provider.

Transition of Care Payment Obligation

When members transition to Vaya from another NC Medicaid health care option, including a Standard Plan or other Tailored Plan, Vaya will honor existing or active prior authorizations on file for the first 90 days to ensure continuity of care.

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; 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.

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.

OON providers without portal access who are not approved to submit via clearinghouse are permitted to file paper claims with Vaya and are required to submit copies of the RA 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.

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.

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). 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, other than allowed copays, 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.

Payment Suspensions

Vaya will suspend claims payment to any network provider 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 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.

Third-party Liability and Subrogation

Vaya's policy is to implement a timely, fair, and consistent process for identification and management of third party liability (TPL) and subrogation resources to ensure Vaya, network providers, Vaya's subcontracted PBM and vision benefit manager, eligible members, and responsible parties comply with coordination of benefits, TPL, and subrogation requirements set forth in applicable federal and state laws, rules, regulations, guidance, Vaya's contracts with NCDHHS, and executed agreements with network providers. Vaya also complies with all applicable federal and state laws, rules, and regulations, including 42 CFR Parts 433, 438, 455, and 456; N.C.G.S. § 122C-146 and N.C.G.S. § 108A-57; and the NC State Plan for Medical Assistance. This policy applies to both Medicaid and State funding managed by Vaya under all health plans we operate pursuant to contracts with NCDHHS, including the Tailored Plan and NC Medicaid Direct PIHP.

NCDHHS Termination as a Medicaid Provider

Vaya will remove any provider, regardless of network status, from our claims payment system and terminate their contract within one business day of receipt of legally valid notice from NCDHHS that the provider is terminated as an NC Medicaid provider. If Vaya has suspended 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.

Overpayments

Providers must pay back any overpayment identified through self-audit or by Vaya. Encounter claims submitted to NCTracks that NCDHHS rejects, denies, or disallows 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 is 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 a provider was 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 your responsibility to update 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 an appeal 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 12, Provider Grievances and Appeals, or request in good faith a payment plan. If you fail to file a provider appeal or 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/MID of the North Carolina 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 overpayment, assessment, or fine, including any penalty and interest. In such cases, we will notify you NCDHHS mandated recovery of the funds from any reimbursement due to you and include a copy of the written notice from NCDHHS mandating the recovery.

APPENDIX A

Commonly Used Acronyms

ACT	Assertive Community Treatment
ADATC	Alcohol and Drug Abuse Treatment Center
AFL	Alternative Family Living
AMH+	Advanced Medical Home Plus
ASAM	American Society of Addiction Medicine
CAP/C	Community Alternatives Program for Children
CAP/DA	Community Alternatives Program for Disabled Adults
CASPs	Cross-Area Service Programs
CCA	Comprehensive Clinical Assessment
CCNC	Community Care of North Carolina
CCP	Clinical Coverage Policy
CFAC	Consumer and Family Advisory Committee
CFR	U.S. Code of Federal Regulations
CDSA	Children's Developmental Service Agency
CIHA	Cherokee Indian Hospital Authority
CIRC	Critical Incident Review Committee
CLS	Community Living and Support
CMA	Care Management Agency
CMARC	Care Management for At-Risk Children
CMHRP	Care Management for High-Risk Pregnancies
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of benefits
CST	Community Support Team
DME	Durable Medical Equipment
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
DMHDDSUS	North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services
DHSR	North Carolina Division of Health Service Regulation
DSOHF	North Carolina Division of State-Operated Healthcare Facilities
DSS	(County) Department of Social Services or North Carolina Division of Social Services
EBCI	Eastern Band of Cherokee Indians

ED	Emergency department
EDI	Electronic Data Interchange
EHR	Electronic health record
EI	Early Intervention
EOB	Explanation of benefits
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EVV	Electronic Visit Verification
FBC	Facility-based Crisis
FCA	False Claims Act
GRIT	Grievance Resolution and Incident Team
HCAC	Health care-acquired conditions
HCBS	Home and Community-Based Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
I/DD	Intellectual/developmental disability
IFDS	Individual and Family Directed Services
IHS	U.S. Indian Health Service
ILOS	In lieu of services
IMD	Institution for Mental Diseases
IPS-SE	Individual Placement and Support – Supported Employment
IRIS	Incident Response Improvement System
JJBH	Juvenile Justice Behavioral Health Partnership
LME/MCO	Local Management Entity/Managed Care Organization
LRP	Legally Responsible Person
LTSS	Long-Term Services and Supports
MCM	Mobile Crisis Management
MID	Medicaid Investigations Division
NABD	Notice of Adverse Benefit Determination
NCAC	North Carolina Administrative Code
NCDHHS	North Carolina Department of Health and Human Services
N.C.G.S.	North Carolina General Statutes
NCQA	National Committee for Quality Assurance
NC-TOPPS	NC Treatment Outcomes and Program Performance System
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
OAH	Office of Administrative Hearings

OIG	Office of Inspector General
OON	Out-of-network
PAC	Provider Advisory Council
PADP	Physician Administered Drug Program
PBM	Pharmacy Benefit Manager
PCCM	Primary Care Case Management
PCP	Primary care provider
PCS	Personal Care Services
PDL	Preferred Drug List
PHI	Protected health information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMP	Pregnancy Management Program
POC	Plan of Correction
PRTF	Psychiatric Residential Treatment Facility
QIA	Quality Improvement Activity
QM	Quality Management
RSVP	Referral Screening Verification Process
RA	Remittance advice
RADSE	Relative as Direct Support Employee
RCC	Regulatory Compliance Committee
RMDM	Records Management and Documentation Manual
SAR	Service authorization request
SDC	State Developmental Center
SED	Severe emotional disturbance
SIU	Special Investigations Unit
SMI	Serious mental illness
SPMI	Severe and persistent mental illness
SSA	Social Security Act
TBI	Traumatic brain injury
TCL	Transitions to Community Living
TCM	Tailored Care Management
TPL	Third-party liability
UM	Utilization management
VAS	Value-added services

APPENDIX B

List of Revisions

Vaya may update this manual once per quarter in the event of substantive updates or revisions that impact providers or Vaya business. Unless directed by NCDHHS, Vaya will not update this Provider Operations Manual more than once per quarter. Submissions of this provider manual to NCDHHS do not replace or eliminate the requirement to annually review and update the provider manual. Vaya will review and update this manual no less than annually to reflect changes to applicable federal and state laws, rules, and regulations, as well as 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 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.

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 Manuals page of our Provider Central website. This manual must be updated within 15 days of notification or request by NC Medicaid, and corrections or revisions to any printed version will be included in the next printing. Any substantive updates or revisions to this 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.

Revisions to this manual are listed below and 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 CFR 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.
- Aug. 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).
- Aug. 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.
- March 14, 2025, Section 14 pages 157-158, updated member rights and added member responsibilities information to align with NCQA requirements and Vaya's member and recipient handbooks.
- Oct. 1, 2025, all sections/all pages, reorganized and revised manual to update for current Vaya operations.
- March 5, 2026, minor formatting, acronym, and capitalization changes throughout manual; Introduction page 9, updated NCQA accreditation status to full, removed mention of DSS-embedded care managers; Section 1 page 12, added EBCI information, page 13 added reference to no ID cards issued for recipients; Section 2 page 27, updated peer-to-peer discussions information; Section 4 page 41, updated allowed OON agreements; Section 7 page 63, updated substance use disorder population language; Section 9 page 74, updated EBCI Tribal Option care management language, page 76 removed Healthy Opportunities Pilot section; Section 10 page 80, updated Level I incident report submission information; Section 11 page 87, updated Prepayment Review section.