PROVIDER OPERATIONS MANUAL

2023

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

Effective April 1, 2023

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VAYAHEALTH

Key Contacts

Provider Support Service Line • Help with general provider questions • Technical assistance	**1-866-990-9712** provider.info@vayahealth.com
Member and Recipient Service Line • General information, benefits, claims, referrals, and access to care • Monday-Saturday, 7 a.m.-6 p.m. (toll-free)	**1-800-962-9003/TTY 711** member.services@vayahealth.com
Behavioral Health Crisis Line • 24/7/365 crisis assistance • Link to Mobile Crisis Management	**1-800-849-6127/TTY 711**
Nurse Line **(Medicaid only – operated by Standard Plan partner)** • 24/7/365 assistance for members with physical health concerns	**1-800-290-1623/TTY 711**
Pharmacy Service Line **(Medicaid only – operated by Pharmacy Benefit Manager)** • Pharmacy and prescriber assistance	**1-800-540-6083/TTY 711**
ADDITIONAL PROVIDER CONTACTS	
24/7 Compliance Hotline • Report fraud, waste, or abuse • Report suspicious billing	**1-866-916-4255** LegalandCompliance@vayahealth.com
Claims and Reimbursement • Billing and reimbursement • RAs, credit memos and service codes	**1-800-893-6246, ext. 2455** Claims@vayahealth.com
Eligibility and Enrollment • Health plan eligibility and enrollment • Client updates	**1-800-893-6246, ext. 2355** EandE@vayahealth.com
Credentialing	***Please call the NCDHHS Vendor Line***
Utilization Management • Service definitions • Prior and retrospective authorizations	**1-800-893-6246, ext. 1513** UM@vayahealth.com
Member Appeals • Peer-to-peer discussions • Reconsideration of authorization decisions	**1-800-893-6246, ext. 1400** Member.Appeals@vayahealth.com
Information Services Division (ISD) Service Desk • Vaya software platform issues • Electronic billing (837/835)	**1-800-893-6246, ext. 1500** ServiceDesk@vayahealth.com
Complaints and Grievances • Report a compliment, complaint, or concern	**1-800-893-6246, ext. 1600** ResolutionTeam@vayahealth.com

Welcome to Vaya

On behalf of all of us at Vaya Health, I am pleased to present to you our Provider Operations Manual for the Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan, which we call Vaya Total Care™. This manual contains vital information for Vaya network providers and practitioners who deliver health care supports and services to Vaya members and recipients.

Vaya Total Care is an integrated health plan designed for individuals with significant behavioral health or I/DD needs. The plan also serves other special populations, including participants in the NC Innovations and Traumatic Brain Injury (TBI) waivers and waiver waitlist members, and is responsible for managing the state's non-Medicaid behavioral health, I/DD and TBI services for uninsured and underinsured North Carolinians. Vaya Total Care invests in the Tailored Care Management model, a community-based, provider-driven approach aimed at advancing whole-person care and better health outcomes.

The work you do is critical for our communities, but it is not easy. Working together with you, alongside our Provider Advisory Council, we will continue to develop and expand a strong network of community-based services and supports. Together, we are making a positive impact in the communities we serve across North Carolina today and for generations to come.

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

Brian Ingraham
CEO, Vaya Health

Mission, Vision and Values

MISSION: Who We Are

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

VISION: What We're Building

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

VALUES: What We Believe In

Person-Centeredness

Interacting with compassion, cultural sensitivity, honesty, and empathy.

Integration

Caring for the whole person within the home and community of an individual's choice.

Commitment

Partnering with members, families, providers, and others to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better.

Integrity

Ensuring quality care and accountable financial stewardship through ethical, responsive, transparent, and consistent leadership and business operations.

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SECTION 1 |
About Vaya Health

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

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

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

This manual and all requirements outlined within it are a binding part of your contract with Vaya and are incorporated by reference therein. Please read it carefully and make sure that your employees and contractors are familiar with the requirements. Note that information or procedures which pertain only to a particular funding source (e.g., Medicaid, federal block grants, or State funds) are identified as such.

If unspecified, the information applies to all Vaya network providers and practitioners, regardless of funding source. Some information also applies to providers who signed an OON Agreement. All references to timeframes in this manual refer to calendar days unless otherwise stated. A "business" or "working" day means Monday through Friday, 8:30 a.m. through 5 p.m., except for any day recognized by Vaya as an official holiday, as well as any day Vaya is not open for administrative functions due to a weather-related event or other natural cause.

Within five (5) days of approval from NC Department of Health and Human Services (NCDHHS or the Department), Vaya will make this Provider Operations Manual available to contracted providers in an electronic version accessible via the Vaya website and/or the Vaya Provider Portal, and in writing upon request of a contracted provider.

To provide suggestions or feedback about the information in this manual, please call Vaya's Provider Support Service Line at 1-866-990-9712 or email us at manuals@vayahealth.com. We look forward to hearing from you.

What is Vaya Health?

Vaya is a local government agency that manages one of North Carolina's Behavioral Health and Intellectual/ Developmental Disabilities (I/DD) Tailored Plans for eligible individuals our 31-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, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey. We operated under the name Smoky Mountain Center for Mental Health, Developmental Disabilities and Substance Abuse Services beginning in 1972 and changed our name to Vaya Health in September 2016.

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

- Standard Plans, which launched July 1, 2021, manage services for most Medicaid beneficiaries.
- Behavioral Health and I/DD Tailored Plans (Tailored Plans), which launch October 1, 2023, and are designed for individuals with significant behavioral health, I/DD, and traumatic brain injury (TBI) needs as well as other special populations. Vaya's Tailored Plan is called Vaya Total Care™.
- Eastern Band of Cherokee Indians (EBCI) Tribal Option.

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

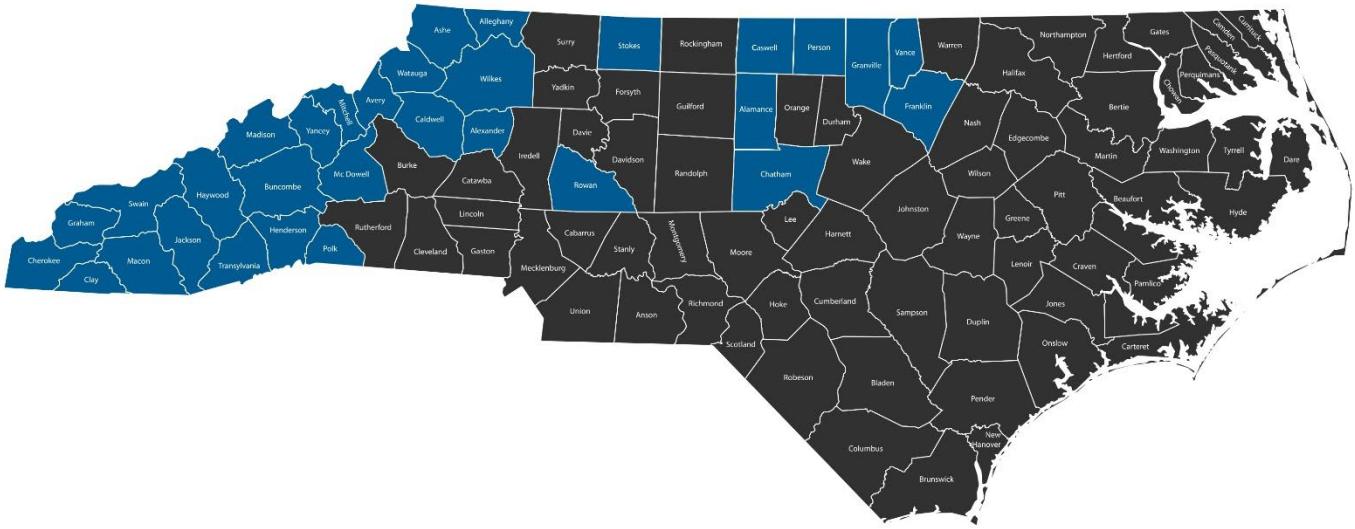
Vaya also manages certain services for Medicaid beneficiaries carved out of managed care through the NC Medicaid Direct plan. Under this plan, NCDHHS manages physical health services, pharmacy, and LTSS, while Vaya manages behavioral health, I/DD, and TBI services. Information about NC Medicaid Direct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

A central feature of Vaya Total Care for Medicaid members is the Tailored Care Management model, a community-based, provider-driven model aimed at advancing whole-person care and better health outcomes. Through Tailored Care Management, Vaya Total Care Medicaid members have a single designated care manager supported by a multidisciplinary care team to provide integrated care management that addresses all identified needs, including physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs. For more information, visit https://medicaid.ncdhhs.gov/transformation/tailored-care-management.

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

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

Vaya Health Region



Vaya is currently accredited by URAC in the areas of Health Call Center, Health Network, and Health Utilization Management. By 2025, we will have obtained Health Plan Accreditation with LTSS Distinction from the National Committee for Quality Assurance (NCQA) as required by NCDHHS. We offer a Member and Recipient Service Line, a 24/7/365 Behavioral Health Crisis Line and a Provider Support Service Line for all members, recipients, and providers. We also oversee a 24/7/365 Nurse Line (Medicaid beneficiaries only) and a Pharmacy Benefits Line.

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

The 1115 Medicaid Service Delivery Waiver Model

The amended NC Medicaid 1115 Demonstration Waiver was approved by the federal Centers for Medicare & Medicaid Services (CMS) on Oct. 24, 2018. The waiver moves the state's Medicaid program toward whole-person care and gives North Carolina federal authority to implement through its managed care plans an innovative Healthy Opportunities pilot program to improve health and reduce health care costs. These pilots will identify the most cost-effective ways for managed care plans to deliver whole-person care and ensure Medicaid dollars are purchasing value. The 1115 Waiver allows for regional Tailored Plans to manage whole-person health services and supports for individuals with significant behavioral health, I/DD, and/or TBI needs.

The NC Innovations 1915(c) Waiver

The Innovations 1915(c) Waiver is an HCBS waiver for people with I/DD, regardless of age, who meet institutional level of care criteria. This waiver allows long-term care services to be provided in home and community-based settings instead of an institutional setting, such as an Intermediate Care Facility for Individuals with Intellectual

Disabilities (ICF/IID). The Innovations Waiver includes some non-medical services, such as home modifications, which are not available under traditional Medicaid.

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

The number of Innovations Waiver participants is limited by CMS and by the availability of slots funded by the state of North Carolina. People who are potentially eligible for the Innovations Waiver may need to wait for funding to become available and are placed on the Registry of Unmet Needs. The registry is a first-come, first-serve list, and network providers must work with families of children who are diagnosed with an I/DD to place them on the registry as soon as possible. Members who are placed on the Registry of Unmet Needs can access any non-Innovations services for which they are eligible. Vaya may also provide additional support for members placed on the registry. For more information about the Innovations Waiver, refer to Section 20 of this manual.

Where is Vaya Located?

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

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

BUNCOMBE COUNTY (ADMINISTRATIVE OFFICES)
200 Ridgefield Court, Suite 218, Asheville, NC 28806
Telephone: 828-225-2785
Facsimile: 828-412-4098

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

ALAMANCE-CASWELL COMMUNITY OFFICE
2929 Crouse Lane, Suite B, Burlington, NC 27215
Telephone: 336-513-4222
Facsimile: 336-229-2725

VANCE COUNTY REGIONAL OFFICE
134 S. Garnett St., Henderson, NC 27536
Telephone: 252-430-1330
Facsimile: 1-877-342-6574

Governance and Administration

Vaya is governed by a Board of Directors appointed in accordance with N.C.G.S. Chapter 122C. Our Board includes six individuals with specific expertise consistent with the nature of managed care operations, a county commissioner representative, a member appointed by the NCDHHS Secretary, a hospital administrator, three members of our Consumer and Family Advisory Committee (CFAC), nine at-large members, and the president of the Vaya Provider Advisory Council, who serves in a non-voting ex officio capacity. The Board provides broad oversight and policy direction for the organization and ensures that Vaya is accountable to community needs and

local government. The Board actively and regularly reviews reports on finances, regulatory compliance, performance, quality, service utilization, member/ recipient services, unmet local service needs, access to services, and provider capacity.

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

Advisory Boards

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

REGIONAL BOARDS

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

CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC)

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

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

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

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

LONG TERM SERVICES AND SUPPORTS (LTSS) MEMBER ADVISORY COMMITTEE

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

HUMAN RIGHTS COMMITTEE

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

Provider Advisory Council

As a network provider, you are encouraged to participate in Vaya's Provider Advisory Council (PAC), which serves as an advisory body to Vaya on issues affecting network providers. The PAC operates pursuant to a set of bylaws and is a self-governing committee that includes representation from a broad cross-section of provider types serving all service areas and all disability groups served by Vaya.

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

1. Fostering partnerships with Vaya to address issues affecting the behavioral health and I/DD public service system.
2. Recommending and supporting the provision of best practices to empower members/recipients within Vaya's region to achieve their personal goals.
3. Fostering communication and collaboration between network providers to improve member/recipient care.
4. Providing input and recommendations to Vaya about clinical and provider payment policies, selection and retention criteria, dispute resolution mechanisms, the Provider Operations Manual, and other guidelines and requirements that directly impact network providers.

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

Code of Ethics

Vaya requires all employees and contractors to practice honesty, directness, and integrity in dealings with one another, business partners, the public, the business community, internal and external stakeholders, members/recipients, suppliers, elected officials, and government authorities. To further this requirement, the PAC developed a Code of Ethics that is incorporated into this manual as Appendix D. All network providers are required to comply with the code as a condition of network participation. Any alleged violation of the code should first be discussed with the network provider. If the issue cannot be resolved informally, allegations of ethics violations may be presented to the PAC and considered in a closed session. The PAC may refer network providers alleged to be in violation of the code to Vaya for investigation and potential adverse action.

Stakeholder and Community Involvement

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

Vaya also maintains collaborative working relationships with a variety of community stakeholder and human service agencies within the region to assess what services are working or needed and to ensure integration of care to support members/recipients who are involved with multiple agencies. These organizations include DSS agencies, local health departments, Federally Qualified Health Centers (FQHCs), community hospitals and regional health systems, public schools, law enforcement, courts, Juvenile Court counselors, the National Alliance on Mental Illness (NAMI), Community Care of North Carolina (CCNC), Area Health Education Centers (including the Mountain Area Health Education Center, known as MAHEC, and the Northwest Area Health Education Center, known as NW AHEC), and primary care providers.

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

Provider Communications and Technical Assistance

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

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

- NC Medicaid Bulletins available at https://medicaid.ncdhhs.gov/providers/medicaid-bulletin.
- Joint NC Medicaid (DHB) and Division of MHDDSAS Communication Bulletins available at https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/joint-communication-bulletins. (Note: Joint Communication Bulletins supersede the previous joint NC Medicaid and Division of MHDDSAS Implementation Updates and the previous Division of MHDDSAS Communication Bulletins).
- NC Medicaid Clinical Coverage Policies available at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

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

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

Please ensure you are signed up to receive Provider Communication Bulletins by visiting https://providers.vayahealth.com/learning-lab/communication-bulletins. We strive to keep our communications meaningful, targeted, and on point to avoid "information overload." However, failing to read Vaya Provider Communication Bulletins is not a valid excuse for non-compliance with requirements. Network providers are required to be aware of changes that affect delivery of publicly funded services by taking actions such as:

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

Provider Portal

Vaya's Provider Portal allows providers the ability to submit claims manually, view and manage all claims (including claims submitted outside the portal, such as EDI claims), view payment information associated with a claim, submit service authorization requests, view and manage all authorizations, submit recipient enrollment requests, and submit requests to update a recipient's information. In addition, providers can view and download this manual, access training materials, and submit both grievances and appeals through either the Provider Portal or an external system linked from the Provider Portal. The Provider Portal is the primary mechanism for sharing data with providers, including:

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

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

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SECTION 2 | Clinical Practice Standards

Physician-Directed Treatment Services

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

PHYSICIAN TEAM LEADERSHIP AND ON-SITE SERVICES

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

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

Schedule II Medications

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

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

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

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

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

Physician Supervision of Mid-Level Prescribers

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

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

Community Safety/Population Health

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

3

SECTION 3 | Benefit Plans, Covered Services, and Utilization Management

Medicaid – the NC 1115 Demonstration Waiver

Vaya's Tailored Plan Medicaid benefit package includes all health services required by the 1115 Demonstration Waiver and the NC State Plan for Medical Assistance (Medicaid State Plan). Vaya's Medicaid 1115 Benefit Plan is available on our website at https://providers.vayahealth.com. Please refer to Appendix A for covered services and associated clinical coverage policies.

Innovations – the NC Innovations Waiver Health Plan/1915(c) Waiver

NC Innovations is a 1915(c) HCBS waiver. Vaya's Innovations Waiver benefit package includes all services required by the 1915(c) Waiver and NC Medicaid Clinical Coverage Policy No. 8P. Vaya's Medicaid 1915(c) Benefit Plan is available at https://providers.vayahealth.com.

State-Funded (non-Medicaid) Benefit Plan

Vaya's State-Funded (Non-Medicaid) Benefit Plan includes behavioral health, I/DD, and TBI services made available through State single stream funding, federal block grants, and county dollars. The State-funded services managed by Vaya act as a public safety net. Vaya is committed to ensuring resources benefit the people who need it most. Vaya targets State funding toward services for individuals who meet priority population criteria based on screening, triage, and referral information. Priority populations are groups of people with the most severe types of mental health disorders, emotional disturbances, and substance use disorders with key complicating life circumstances, conditions, and/or situations.

State-funded services are not an entitlement. Vaya can fund services under this benefit plan only within the resources allocated to us. Other than crisis or emergency services, State-funded services are generally not available to undocumented individuals. Residential treatment is generally not covered under the State-funded Benefit Plan. If funds are available, exceptions may be made in limited circumstances where there is an identified, specific, significant health and safety risk to an individual, immediate family member, or the community; when the requested service is designed to treat the individual's disorder; and no other funds are available.

Please refer to Appendix B for the list of covered State-funded behavioral health, I/DD, and TBI services. State-funded behavioral health and I/DD benefit plans are available on our website at https://providers.vayahealth.com.

Pharmacy

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

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

Additionally, prescribers are encouraged to prescribe generic medications when therapeutically equivalent drugs are available within the drug class.

Preferred Drug List (PDL)

Vaya has adopted the NC Medicaid PDL, available at https://medicaid.ncdhhs.gov/preferred-drug-list.

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

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

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

The NC Medicaid PDL Review Panel meets at least annually to review current coverage, consider new-to-market medications, and review PDL recommendations from the public. Requests to add or change the NC Medicaid PDL can be submitted to NCDHHS or to Vaya's Pharmacy Director of North Carolina Medicaid Managed Care Program for consideration. Additionally, providers and community members may request to speak at a PDL Review Panel Meeting by emailing Medicaid.PDLReviewMeeting@dhhs.nc.gov.

- If there are changes to the PDL and other formulary medications, Vaya will:
- Include updates in the Provider Communication Bulletin;
- Post updates to the Vaya website; and
- Send member-specific communication to the provider if a formulary change directly impacts the member's care.

Generic Medications

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

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

Coverage Limitations

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

- Products that are experimental, investigational, or part of a clinical trial.
- Over the counter (OTC) drugs, except as included on the PDL and in Policy 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 US Food and Drug Administration (FDA) (e.g., Drug Efficacy Study Implementation [DESI] drugs)
- Products being used for a purely cosmetic reason.
- Drug samples or prescriptions being covered by a manufacturer's patient assistance program.
- Prescription-only vitamins, minerals, and supplements.
- Fertility drugs.
- Drugs to treat erectile dysfunction.
- Products to promote weight loss or weight gain.
- Cough/cold products that contain an expectorant or cough suppressant.

Medication-Specific Limits

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

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

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

To request an appeal of an adverse benefit determination, prescribers must call the Pharmacy Service Line (1-800-540-6083) or submit the appeal request form available in the Provider Portal. Vaya's policy is to complete all

appeal reviews no later than 30 days after the appeal is received. Prescribers may request an expedited appeal when an adverse benefit determination could jeopardize a member's health or safety. Expedited appeals are resolved no later than 72 hours after receipt of the completed request.

Injectable and Infusion Services

The NC Medicaid Physician Administered Drug Program (PADP) covers drugs purchased for use in an outpatient setting under the pharmacy benefit with no prior authorization requirement. A list of medications covered under the PADP and the corresponding fee scheduled is available at https://medicaid.ncdhhs.gov/providers/programs-and-services/prescription-drugs/physician-administered-drug-program.

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

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

To access the list of medications requiring prior authorization, prior authorization forms, and clinical coverage policies, visit https://medicaid.ncdhhs.gov/pharmacy-services-clinical-coverage-policies.

Vaya Health Lock-in Program

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

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

Durable Medical Equipment

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

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

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

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

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

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

DME UTILIZATION MANAGEMENT

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

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

signed by the physician, physician assistant, or nurse practitioner for the continued coverage. The provider must obtain the signed form before billing for any services beyond 12 months.

DME PROVIDER REQUIREMENTS

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

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

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

DME PROOF OF DELIVERY

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

DME DOCUMENTATION

Providers must keep the following documentation of their services:

- The prescription for the item signed by the physician, physician assistant, or nurse practitioner specifying the order (such as the quantity ordered, frequency of use, duration of prescription).
- The original CMN/PA form for DME and supplies.
- The original orders signed by the physician, physician assistant, or nurse practitioner that were used to provide enteral nutrition.
- A full description of all items supplied to a member.
- The dates the items were supplied, including the delivery date for purchased items or the delivery/pickup dates for rental items and signed pick-up and delivery slips. The delivery slip must be signed by the member or their designee when the delivery is direct to the member.

- A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair. If the item is removed from the member's environment for service or repair, the record must include the date of removal and the date of return.

DME MONITORING

Vaya's Quality Management department and the Special Investigations Unit (SIU) monitor providers of DME to Vaya members. Information gathered during any monitoring process that suggests misuse of public funds or member or provider fraud, waste, or abuse will be referred to the SIU. Vaya may also make a referral to another agency, such as the North Carolina Board of Pharmacy, depending on the nature of the grievance and/or complaint. Please refer to Section 15 Member Rights and Empowerment, Section 5 Provider Responsibilities, Section 13 Performance Improvement Procedures, and Section 17 Provider Program Integrity Requirements of this manual for detailed information about monitoring. For additional information, refer to https://medicaid.ncdhhs.gov/durable-medical-equipment or the CMS Final Rule at 42 CFR § 440.70.

Prior Authorization Requirements

Please note that not all Vaya-managed services require prior authorization. **Vaya does not require prior authorization for any pharmacy or physical health service that does not require prior approval per NC Medicaid Clinical Coverage Policies**, available at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

Vaya does not require prior authorization for select behavioral health services as noted below:

- Outpatient therapy (group or individual): Prior authorization is not required.
- Multisystemic therapy (MST): Prior authorization is not required.
- Psychological testing:
  - Medicaid: Prior authorization is not required for up to eight units for adults and up to 16 units for children in any 12-month period. After these limits are reached, prior authorization is required.
  - State-funded services: Prior authorization is required.
- MCM: Prior authorization is not required for the first eight hours per episode of care.
- Inpatient psychiatric services:
  - Medicaid: The first seven days per episode of care do not require prior authorization. A notification of admission is required to access pass-through days. Prior authorization for continued inpatient services after the first seven days is required.
  - State-funded services: Prior authorization is not required for the first three days per episode of care. A notification of admission is required to access pass-through days.
- FBC services:
  - Medicaid: The first seven days per episode of care do not require prior authorization.
  - State-funded services: Prior authorization is not required.
- Substance Abuse Intensive Outpatient Program (SAIOP): If a member receives more than two full treatment episodes in one State fiscal year, authorization is required to begin a third episode within the fiscal year.
- Psychosocial rehabilitation:
  - Medicaid: Prior authorization is not required.
  - State-funded services: Prior authorization is required.

- Outpatient opioid treatment:
  - Medicaid: Prior authorization is not required.
  - State-funded services: Prior authorization is required.
- Supported employment/long-term vocational services:
  - Medicaid: Prior authorization for continued services is required after 64 units. Medicaid members must access Medicaid (b)(3)-funded SE services.
  - State-funded services: Individual Placement and Support – Supported Employment (IPS-SE) does not require authorization.

All other behavioral health services require prior authorization unless otherwise identified in the provider's contract with Vaya. Note that practitioners may freely communicate with members/recipients about their treatment, regardless of benefit coverage limitations.

Vaya's compensation structure for employees and contractors who perform utilization review or utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services to any member or recipient.

PROVIDER RESPONSIBILITY

Requesting authorization, supporting the request with required documentation, and demonstrating medical necessity is the responsibility of the provider who will be delivering the service. A providers may not request authorization on behalf of another provider. Before requesting authorization for services, the first step is to complete a Comprehensive Clinical Assessment (CCA) addressing the elements required by the applicable NC Medicaid Clinical Coverage Policy. Vaya can only process a complete, valid request. If the SAR is not completed fully, including all required administrative and clinical information, it may be returned, delayed, or denied.

Vaya staff may refer network providers who routinely fail to timely and fully complete SARs for investigation, as this directly impacts continuity of care for the individuals we serve. Note that behavioral health clinical home providers generate and submit an individual's service plan for all services but may request authorization for only those services that they provide.

HOW DO I COMPLETE AND SUBMIT A SAR?

- A SAR must be submitted for each service requiring authorization.
- Except for requests based on retrospective Medicaid eligibility, all SARs must have a service start date that is on or after the date of SAR submission.
- To facilitate communication with Vaya about SARs, include the name of the individual who is providing the service or who is most knowledgeable about the case and that person's telephone number at the end of the Justification for Service Request field.
- SARs must be submitted electronically via the Provider Portal. Please note that SARs for specific medical services are reviewed by a delegated subcontractor. The Provider Portal contains instructions and/or a link to submit the request directly to the delegated subcontractor. In documented instances where electronic transmittal is not possible, Vaya may accept transmittal via facsimile, US mail, or hand-delivery. Providers are responsible for maintaining documentation showing the date the request was submitted.
- **Network providers can request specific technical assistance about SAR submission by contacting Vaya's Utilization Management team at 1-866-990-9712, option 5.**

WHEN DO I SUBMIT A SERVICE AUTHORIZATION REQUEST (SAR)?

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

WHEN DOES VAYA RETURN A SAR AS UNABLE TO PROCESS?

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

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

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

- Identical or duplicate request, i.e., the provider submits two requests for the same service/same dates for a member/recipient OR two different providers submit the same request for the same member/recipient, in which case Vaya will process the first request received and return the second request as unable to process.
- The member/recipient is not enrolled in a Vaya health plan.

- The request/supporting documentation contains inconsistent or conflicting information (e.g., name and Medicaid Identification Number do not match).
- The diagnosis or service is not covered by the applicable benefit plan, (e.g., the provider submits a request for a service that is covered only by NC Medicaid Direct).
- Funding is not available for a State-funded or (b)(3) service.
- The service does not require prior authorization.

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

SUPPORTING DOCUMENTATION

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

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

SERVICE PLANS

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

If a member/recipient does not have a behavioral health clinical home, the provider must collaborate with other providers in developing the service plan. For Innovations Waiver participants, the plan is submitted for approval by the assigned care manager. Service plans must be submitted to Vaya upon development of the initial plan following the initial assessment, at least annually thereafter, and whenever significant changes occur in the member's/recipient's situation and/or plan of care, including all changes to recommended services.

LEVEL OF CARE/PLACEMENT CRITERIA

Vaya requires that all SARs for behavioral health services include results from the following clinical decision support tools as applicable to the member/recipient or service being requested:

- NC Support Needs Assessment Profile (NC-SNAP), a needs assessment tool that measures an individual's level of intensity of need for I/DD supports and services. The NC-SNAP was developed by NCDHHS and officially adopted in 1999 as the requisite tool for determining an individual's intensity of need for I/DD services. As part of the shift to the resource allocation model, Vaya and other MCOs are in the process of phasing out the use of NC-SNAP in favor of the Supports Intensity Scale® (SIS).
- The SIS is a tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) that measures the individual's support needs in personal, work-related, and social activities to

identify and describe the types and intensity of the supports an individual requires. The SIS was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. All Vaya SIS assessors are trained by AAIDD in administration of the SIS. For more information, please see Section 4 of this manual or http://aaidd.org/sis.

- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC), the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of individuals with substance use disorders and co-occurring conditions. For more information, visit https://www.asam.org/asam-criteria.

NOTE: Completion of one of the above approved leveling tools is required even for behavioral health services that do not require prior authorization.

INITIAL REVIEW PROCESS

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

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

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

If Vaya determines the request meets medical necessity and/or EPSDT criteria, we will approve the SAR, resulting in generation of an electronic authorization letter, available in the MCIS for your review. Please visit https://providers.vayahealth.com/ or contact the Vaya Service Desk for help accessing authorization information. The authorization contains provider and member/recipient identification, authorization/tracking numbers, the name and total number of units of the service authorized, and authorization effective dates. The provider is responsible for notifying the member/recipient when a service is approved. We do not send notifications to members/recipients unless the request is denied (in whole or in part). **Note that authorization does not guarantee payment. Payment by Vaya is subject to other requirements and limitations set forth in your contract, this manual, and any other guidance or manuals published by Vaya.**

PEER REVIEW

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

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

If Vaya issues a medical necessity denial without having conducted a peer-to-peer discussion, the provider may request one within three business days of the denial notice. If the clinical peer reviewer who made the initial decision is not available, the provider will speak with another equivalent peer reviewer. This discussion is not an appeal of the adverse benefit determination. Rather, it provides an opportunity to discuss the decision and reasons for the denial. Based on the peer-to-peer discussion, the peer reviewer may decide to change the initial decision.

HOW MUCH TIME DOES VAYA HAVE TO REVIEW THE SAR?

- Routine reviews: We will issue a decision within 14 days after we receive a complete SAR. We can extend the deadline up to 14 additional days under certain circumstances, but this is rare.
- Expedited reviews: Providers can request expedited review of a SAR if they believe the standard timeframe could seriously jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. If expedited review criteria are met, we must complete the expedited review within 72 hours of the request. We can extend the deadline up to 14 additional days under certain circumstances, but this generally does not occur as it defeats the purpose of an expedited review.
    - If we agree the request meets expedited criteria, we will notify you and/or the member/recipient by phone. We will send a written decision no more than three days after the phone notification.
    - If we do not agree expedited review is necessary, we will notify you and the member/recipient and process the request within 14 days. Denial of expedited review cannot be appealed, but you or the member/ recipient can file a grievance or complaint if you disagree with our decision.
- Inpatient hospitalization and FBC reviews: We will issue a decision within 72 hours of the initial request. If we receive a request to extend a current course of treatment more than 24 hours before the end of the current authorization, we will make every effort to issue a decision within 24 hours.

Note the above timeframes apply regardless of whether the authorization request is prospective (the service not currently authorized for the individual), concurrent (the service is currently authorized for the member), or retrospective (the service was already delivered, and the provider is seeking authorization to ensure reimbursement).

MEDICAL NECESSITY

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

- Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance use condition;
- Consistent with Medicaid policies and national or evidence-based standards, NCDHHS-defined standards, or verified by independent clinical experts at the time the procedures, products, and the services are provided;
- Provided in the most cost-effective, least restrictive environment that is consistent with clinical standards of care;
- Not provided solely for the convenience of the member/recipient, their family, custodian, or provider;

- Not for experimental, investigational, unproven, or solely cosmetic purposes;
- Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with 42 CFR, the Medicaid State Plan, the North Carolina Administrative Code, NC Medicaid Medical Coverage Policies, and other applicable federal and state directives;
- Sufficient in amount, duration, and scope to reasonably achieve its purpose; and
- Generally recognized as an acceptable treatment when paired with the reported diagnosis(es) regarding intensity, duration of service, and setting of treatment.

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

- Conform with any advanced medical directive prepared by the individual/legally responsible person (LRP);
- Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- Prevent the need for involuntary treatment or institutionalization.

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

EPSDT is a part of the federal Medicaid law that requires state Medicaid programs to pay for regular screenings and certain services for children under age 21, even if the services are not included in the State Medicaid Plan or applicable Medicaid waiver. Services approved under EPSDT must be medically necessary to correct or ameliorate a defect, physical or mental illness, or condition identified through the screening and must meet all the following criteria:

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

Vaya reviews all requests submitted for Medicaid services for children under age 21 against these criteria. Please remember that all prior authorization requirements also apply to EPSDT services. In addition to coverage of behavioral health services not traditionally covered by Vaya, service coverage under EPSDT means that UM policy, applicable Medicaid waiver, and NC Medicaid Clinical Coverage Policy limits on hours, units, and visits that apply to adults may not apply to children under age 21. However, the Innovations Waiver annual budget limit cannot be exceeded under EPSDT. To request services for a child under the EPSDT benefit, providers must submit the EPSDT Non-Covered Service Request Form available at https://providers.vayahealth.com.

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

Notices of Approval/Denial

The SAR review may result in a full approval, partial approval, or a full administrative or clinical denial. If we issue a partial approval or denial, the member/recipient receives a written notice that includes information about

appeal rights and an Appeal Request Form. All written notices are sent via certified mail to the address on file in our system.

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

Member and Recipient Appeal Process

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

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

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

MEDICAID SERVICE APPEALS

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

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

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

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

Expedited Appeals

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

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

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

Continuation of Benefits

There is no "maintenance of service" under NC Medicaid Managed Care or NC Medicaid Direct. However, if Vaya reduces, suspends, or terminates a previously authorized service, we will continue the service if all following conditions are met:

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

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

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

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

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

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

Second Opinion

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

Vaya Clinical Practice Guidelines

All UM decisions are consistent with clinical practice guidelines adopted by Vaya. Vaya is not required to adopt a guideline for every service we manage, but all guidelines are adopted through a Clinical Advisory Committee that includes provider and CFAC participation. Guidelines are based on valid and reliable clinical evidence (evidence-based practices) or a consensus of licensed professionals. We also may adopt clinical practice guidelines promulgated by a nationally recognized peer review organization, such as the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP).

Clinical practice guidelines are designed to guide providers on how to follow national and community standards of practice. Providers are expected to maintain or advance the quality of services through the demonstration of practice consistent with the adopted clinical practice guidelines and suggested best practices. Clinical practice guidelines are not a substitute for the advice of a health care professional or the utilization reviewer or peer reviewer making medical necessity determinations. Guidelines are available at https://providers.vayahealth.com. In addition, providers must adhere to DHB clinical coverage policies, which can be found at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

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SECTION 4 | Care Management

Vaya provides access to integrated Tailored Care Management (TCM) to eligible Vaya Total Care and NC Medicaid Direct members who choose to participate. Members may receive TCM from a provider-based organization or from Vaya. TCM is a free benefit and is available to eligible members continuously throughout their enrollment, regardless of geography, unless the member is receiving duplicative care management services as part of another service or program. TCM is provided as close as possible to where the member lives or receives care to improve health outcomes. It includes enrollment, assignment, outreach and engagement, assessment, care plan development, crisis plan development, care team formation, transitional and ongoing care management, and diversion. TCM is based on the federal health home structure, and the care management delivered must meet those requirements. These requirements are available at https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

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

Other components of TCM include:

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

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

Tailored Care Management Staffing Requirements

SUPERVISING CARE MANAGERS

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

- Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensed RN; and
- Have three years of experience providing care management, case management, or care coordination to the population being served.

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

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

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

CARE MANAGERS

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

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

CARE MANAGER EXTENDERS

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

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

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

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

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

Care manager extenders must:

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

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

A range of individuals may meet these qualifications, including:

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

CLINICAL CONSULTANTS

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

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

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

Enrollment, Referral, and Assignment for Tailored Care Management

ENROLLMENT AND ASSIGNMENT

All members eligible for the Tailored Plan and NC Medicaid Direct (including Innovations and TBI waiver participants) who were not part of a group delayed or excluded from NC Medicaid Managed Care are eligible for and are "auto-enrolled" in TCM except for members participating in the following services or programs, which include a duplicative care management element:

- Assertive Community Treatment (ACT) services.
- ICF/IID services.
- Care Management for At-Risk Children (CMARC).
- High-Fidelity Wraparound.
- Care management through the NCDHHS Primary Care Case Management (PCCM) vendor.
- Case management through the CAP/C and CAP/DA programs.

- Nursing facility residential services , when the member has resided, or is likely to reside, in the facility for at least 90 calendar days.

The following populations are prioritized for engagement into TCM:

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

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

TCM is provided through one of the following three entities:

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

Following the member's PCP assignment, Vaya assigns members to one of the TCM approaches above. This assignment process prioritizes community-based TCM over plan-based TCM. Vaya ensures that all members, including Innovations participants, have a choice in their care management approach. As part of the TCM assignment process, Vaya considers a variety of member-specific factors, including:

- Member choice.
- Existing relationship with a PCP practicing within an AMH+.
- Existing relationship with a behavioral health provider practicing within a CMA or CMA-affiliated provider agency.
- The complexity of the member's medical, behavioral health, I/DD, and/or TBI needs.
- The member's geographic location and proximity to the TCM provider.
- The mix of acuity levels at the potential assignment site. Vaya monitors TCM assignments to ensure AMH+s and CMAs do not select members for their panel based on acuity tier to avoid serving members at a certain acuity level.
- TCM provider capacity to serve particular disability categories and age groups at the potential assignment site (e.g., expertise and experience in working with subpopulations).
- Volume of engaged TCM participates at potential assignment site. Vaya assigns a sufficient volume of members to AMH+ and CMA sites to allow these organizations to substantially engage in the TCM model (i.e., achieve economies of scale in their TCM staffing). Vaya also permits AMH+s and CMAs to set limits on their panel sizes (i.e., to decline assignments based on capacity).

- To maintain automatic TCM assignment by Vaya, TCM providers must regularly inform Vaya of their capacity for accepting new members for TCM, including any limitations on capacity (e.g., only youth, only members with behavioral health diagnoses, up to 250 adults).
- Vaya assigns participants in the Innovations or TBI waivers to TCM providers who comply with federal requirements for conflict-free case management for 1915(c) Waiver enrollees as outlined at 42 C.F.R. § 431.301(c)(1)(vi).

OUTREACH AND ENGAGEMENT

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

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

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

Coordination with County Child Welfare Workers

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

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

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

DSS Child Health Summary Components, to the extent available;

- Placement logs;
- The member's family history and foster care placement status;
- The member's immediate needs, including behavioral health and unmet health-related resource needs;
- The member's medication history;
- Child Maltreatment Evaluations, as applicable;
- Key updates on the member's permanency planning process;
- Identification of any restrictions to communicating with the biological/adoptive parents, including termination of parental rights or a court order restricting communication; and
- Other information necessary to inform the care management comprehensive assessment and care planning processes.

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

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

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

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

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

Care Management Comprehensive Assessment

Upon TCM provider assignment, the assigned care manager must initiate contact and make best efforts to begin the Care Management Comprehensive Assessment (CMCA) with the member within 30 calendar days of TCM assignment. Members in foster care/the adoption assistance program and former foster youth are prioritized for CMCA outreach prior to beginning outreach to other members. Contact for purposes of starting the CMCA may be telephonic, through two-way real time video and audio conferencing, or in person. The care manager must make "best efforts" to complete the CMCA in person; however, based on the member's needs the assessment may be completed using audio and video conferencing tools. Vaya sends a monthly report listing all members who received the Standardized Unmet Health-Related Resource Needs screening as a required element of the CMCA to DHB.

"Best efforts" are defined as at least three documented follow-up attempts to contact the member (such as going to the member's home or working with a known provider to meet the member at an appointment) if the first attempt is unsuccessful, for a total of four attempts. These attempts must occur over a two-week period and include at least two of the following methods: telephonic, regular mail, email, or fax.

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

- Members identified as high acuity: Best efforts to complete the CMCA within 45 days and no longer than 60 days of plan enrollment.
- Members identified as medium/low acuity: Within 90 days of plan enrollment.
- During contract years after Contract Year 1, care managers make best efforts to complete the CMCA for new members within 60 days of plan enrollment.

The CMCA, at a minimum, must address the following for all members:

- Immediate care needs.
- Current services and providers across all health needs.
- Functional needs, accessibility needs, strengths, and goals.
- Other state or local services currently used.
- Physical health conditions, including:
    - Dental conditions;
    - Chronic health conditions, including chronic pain (defined as pain that typically lasts greater than three months or past the time of normal tissue healing); and
    - Acute health conditions.
- Current and past mental health and substance use status and/or disorders, including tobacco use disorders.
- Physical disabilities or I/DD.
- Detailed medication history that includes a list of all medicines, including over the counter and prescribed drugs dispensed or administered, and known allergies.
- Advanced directives, including advance instructions for mental health treatment.
- Available informal, caregiver, or social supports.
- Standardized Unmet Health-Related Resource Needs questions provided by NCDHHS (i.e., the nine Care Needs Screening questions) covering the four identified priority domains:
    - Housing
    - Food

  - Transportation
  - Interpersonal violence/toxic stress
- Member's eligibility for Vaya's prevention and population health programs (for more information, visit https://providers.vayahealth.com).
- Any other ongoing conditions that require a course of treatment or regular care monitoring.
- (For adults only) exposure to adverse childhood experiences (ACEs) or other trauma.
- Risks to the health, well-being, and safety of the member and others with whom they share a residence (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols).
- Cultural considerations (e.g., ethnicity, religion, language, reading level, health literacy ability).
- Employment/community involvement.
- Education, including Individualized Education Programs (IEPs) and lifelong learning activities.
- Justice system involvement (adults) or juvenile justice system involvement and/or expulsions or exclusions from school (children and adolescents).
- Risk factors that indicate an imminent need for LTSS.
- Caregiver strengths and needs.
- Upcoming life transitions (e.g., changing schools, employment, moving, change in caregiver/natural supports).
- Self-management and planning skills.
- Receipt of and eligibility for entitlement benefits, such as Social Security benefits and Medicare.

For members with an I/DD or TBI diagnosis, the CMCA must address the following additional elements:

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

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

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

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

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

The care manager must incorporate the results of the Member Services Care Coordination (MSCC) Assessment into the CMCA, to the extent feasible. Vaya provides MSCC Assessment results to the TCM provider within seven calendar days of the screening or within seven calendar days of assignment to a new TCM provider, whichever is

earlier. To prevent duplication of identification and assessment activities, Vaya also makes the MSCC Assessment results available to NCDHHS and any other designated care management entity (e.g., PCCM vendor, CAP/C or CAP/DA case management entity, CDSA, other LME/MCOs, PIHPs, and PAHPs) that may be serving the member within seven calendar days of the screening.

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

- If the member's care plan annual update is in the first six months of Year 1 of Tailored Plan launch, Vaya's Tailored Care Management Oversight Team ensures the assigned TCM provider completes the CMCA prior to completing the care plan.
- If the member's annual update is in the second half of Year 1 of Tailored Plan launch, Vaya ensures the assigned TCM provider completes the CMCA according to required timeframes noted above for completion of the CMCA. Vaya ensures the TCM provider completes the CMCA prior to the annual update, and, in subsequent years, aligns the timing of the reassessment with the care plan annual update.
- The care plan developed prior to Tailored Plan launch will continue to serve as the care plan under TCM in Year 1 of Tailored Plan operation, until updated.
- Vaya ensures the care plan is aligned with TCM requirements at the member's next annual update (during the month before the individual's birth month) after a triggering event or at the member's request. Prior to the annual update, the member's CMCA results may be used to amend the care plan if appropriate, but a full update is not required.
- When determining required care management contacts for Innovations or TBI waiver participants, the TCM provider must adhere to the following requirement that is higher in frequency and modality (e.g., number of in-person contacts):
    - The contact requirements found in the 1915(c) Waiver; or
    - The contacts noted below in "Ongoing Care Management".
- For Innovations Waiver participants, Vaya ensures SIS results are shared with the care manager in an electronic format to aid completion of the CMCA.
- Assessment practices and requirements are informed by and coordinated with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.
- The care manager must share the results of the CMCA with the member's PCP and behavioral health, I/DD, TBI and LTSS providers within 14 days of completion to inform care planning and treatment planning per member consent, if legally required.
- Reassessments for members engaged in TCM must be conducted according to the following requirements and within 30 days of the event or change:
    - On an annual basis (Vaya will also attempt to conduct a CMCA at least annually for members who have neither opted out of nor engaged in TCM and are not receiving services duplicative of TCM).
    - When the member's circumstances, needs, or health status changes significantly.
    - After significant changes in scores on NCDHHS-approved level-of-care determination and screening tools (e.g., ASAM, Child and Adolescents Needs and Strengths [CANS], SIS, and Rancho Los Amigos Levels of Cognitive Functioning Scale).
    - At the member's request.
    - After triggering events, including:
        - Inpatient hospitalization for any reason.

- Two ED visits since the last CMCA (including reassessment).
- An involuntary treatment episode.
- Use of behavioral health crisis services.
- Arrest or other involvement with law enforcement/the criminal justice system, including the Division of Juvenile Justice (DJJ).
- Becoming pregnant and/or giving birth.
- A change in member circumstances that results in an increased need for care, a decreased need for care, transition into or out of an institution, loss of a family/friend/caretaker, or any other event the plan deems to be a change in circumstance.
- Loss of housing.
- Foster care involvement.

In circumstances in which a comprehensive assessment has been performed withing the previous six months, reassessment consists of an addendum or update to a previous comprehensive assessment.

Development of the Person-Centered Plan or Care Plan

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

- Ensures meetings related to the member's person-centered plan or care plan are held at a location, date, and time convenient to the member and the member's chosen care team.
- Ensures each person-centered plan or care plan is individualized and developed using a collaborative approach that includes member and care team participation.
- Develops and presents the person-centered plan or care plan in an understandable manner, including consideration for reading level to support the member's understanding and ability to actively participate in the self-management aspects of their plan. The care manager explains and helps the member understand the plan. The care manager reviews the plan with the member to further refine it and prioritize goals; add additional concerns, goals, and/or interventions; and include the member's own language/words.
- Includes barriers to the accomplishment of each goal as needed and as identified by the care team.
- Ensures best efforts are made to complete an initial person-centered plan or care plan within 30 days of CMCA completion. The care manager ensures plan development does not delay the timely provision of needed services to a member, even if the member is waiting for a plan to be developed, with the exception of Innovations Waiver, TBI Waiver, or any forthcoming 1915(i) services, for which prior authorization must be documented in the person-centered plan or care plan. If a member needs an Innovations Waiver, TBI Waiver, or any forthcoming 1915(i) service before the plan is fully developed, the care manager completes the minimum elements for the SAR.
- Incorporates the results of the CMCA (including questions about unmet health-related resource needs), claims analysis and risk scoring, available medical records, and screening and/or level of care determination tools, including the following, as appropriate:
    - CANS
    - ASAM criteria
    - For Innovations Waiver participants: SIS
    - For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale

- For interventions that include providing or discussing strategies with members to support management of their health conditions, contains, at a minimum:
    - Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery; and
    - Measurable member goals.
- Clinical needs, including any physical health, behavioral health, I/DD, TBI, or dental needs.
- Interventions, including medication management and adherence.
- Intended outcomes of interventions and goals.
- Social, educational, and other services needed by the member.
- Strategies to increase social interaction, employment, and community integration.
- Emergency/natural disaster/crisis plan.
- Strategies to mitigate risks to the health, well-being, and safety of the member and others.
- Information about advance directives, including advance instructions for mental health treatment, as appropriate.
- A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving, or entering another life transition.
- Strategies to improve self-management and planning skills.
- For members with serious emotional disturbance (SED), I/DD, or TBI, the person-centered plan or care plan should also include caregiver supports, including connection to respite services, as necessary.

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

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

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

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

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

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

Response Times for Inquiries from Key Partners

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

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

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

Care Team Formation

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

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

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

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

Ongoing Care Management

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

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

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

Additionally, the TCM provider must:

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

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

TCM incorporates individual and family supports, including:

- Training the member in self-management.
- Providing education and guidance on self-advocacy to the member, family, and supports;
- Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system.
- Providing information and connections to needed services and supports, including but not limited to self-help services, peer support services, and respite services.

- Providing information to the member, family, and supports about the member's rights, protections, and responsibilities, including the right to change providers, the grievance resolution process, and fair hearing processes. This information is included in Vaya's Tailored Plan Member Handbook and NC Medicaid Direct Member Handbook, which are provided or made accessible to all members upon enrollment in a Vaya health plan.
- Promoting health, including wellness and prevention programs.
- Providing information about establishing advance directives, including advance instructions for mental health treatment and guardianship options/alternatives, as appropriate.
- Connecting members and their family to resources that support maintaining employment, community integration, and success in school, as appropriate.
- For high-risk pregnant individuals, inquiring about broader family needs, offering family planning guidance, and beginning discussions about a potential Infant Plan of Safe Care.
- Coordinating with services provided by community and social support providers to address unmet health-related resource needs, including, at a minimum:
    - Provision of referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services, including:
        - Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery [SOAR]).
        - Food and income supports.
        - Housing.
        - Transportation.
        - Employment services.
        - Education.
        - Child welfare services.
        - Domestic/interpersonal violence services.
        - Legal services.
        - Services for justice-involved populations.
        - Other services that help individuals live their highest level of function and independence.
- Using NCCARE360 to identify and connect the member to community-based resources by:
    - Using the community-based organization and social service agency resource repository to identify local, community-based resources;
    - Referring the member to organizations and agencies available through NCCARE360; and
    - Tracking closed-loop referrals.
- Providing comprehensive assistance securing key health-related services, including helping complete and submit initial applications and renewals and gathering and submitting required documentation. This assistance may be either in-person or electronic, at the member's preference and depending on the most efficient, effective, and feasible approach. The care manager helps with support for the following programs, at a minimum:
    - Food and Nutrition Services (food stamps)
    - Temporary Assistance for Needy Families (Work First)
    - The Child Care Subsidy program
    - Low Income Energy Assistance Program (LIEAP)
    - ABLEnow Accounts (for individuals with disabilities)
    - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
    - Vaya Total Care programs that address unmet health-related resource needs.
- Ensuring a member has a postpartum visit with a physician within 56 days of delivery to assess for signs of postpartum depression.

CONTACT REQUIREMENTS

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

Required contacts for members with behavioral health needs are:

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

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

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

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

- For members in foster care/the adoption assistance program and former foster youth, the TCM provider ensures close coordination, as appropriate, with the assigned DSS county child welfare worker to identify and manage emerging member needs.
- At the request of the county child welfare worker and at the member's discretion, the TCM provider participates in the initial development of and periodic updates to the member's Transitional Living Plan. The TCM provider works in partnership with the member's other providers to help the member and county child

welfare worker identify key health care-related goals, as well as resources and supports needed to meet those goals, to include in the member's Transitional Living Plan.

- The care manager participates in the development of the member's DSS 90-Day Transition Plan with the assigned county child welfare worker, family, providers, and other support individuals at the discretion of the member and county child welfare worker. The DSS 90-Day Transition Plan includes accurate, up-to-date contact information for the member's care manager, PCP, dental home, behavioral health and/or I/DD providers, and current medications, as applicable.
- For members who remain enrolled, the care manager makes best efforts to conduct the CMCA/reassessment within 90 calendar days of the member leaving the child welfare system.

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

Other Care Management Programs

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

CARE MANAGEMENT FOR AT-RISK CHILDREN (CMARC)

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

CARE MANAGEMENT FOR HIGH-RISK PREGNANT WOMEN (CMHRP)

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

need and sends all screening information to the applicable LHD to begin providing CMHRP within one business day of the referral.

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

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

CMHRP interventions must include, but are not limited to:

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

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

has the right to appeal the termination. Vaya must notify NCDHHS of underperformance by or contract termination of an LHD.

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

PREGNANCY MANAGEMENT PROGRAM (PMP) IN COORDINATION WITH CMHRP

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

HIV Case Management

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

COORDINATION WITH CHILDREN'S DEVELOPMENTAL SERVICE AGENCIES (CDSAS)

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

1. Incorporate the child's Individualized Family Service Plan (IFSP) into the person-centered plan or care plan;
2. Update the plan on an ongoing basis to reflect any changes to the IFSP;
3. Request that the CDSA service coordinator participate in the child's care team meetings, upon consent of the parent/LRP; and
4. Partner with the CDSA service coordinator to identify any unmet health-related resource needs and connect the family to appropriate social and community-based services.

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

TRIBAL OPTION

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

PRIMARY CARE CASE MANAGEMENT (PCCM)

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

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

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

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

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

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

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

Healthy Opportunities Pilots

Effective October 1, 2023, in partnership with network lead Impact Health, Vaya administers the State's Healthy Opportunities Pilot program in 16 counties: Avery, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, and Yancey. The pilot program covers a select set of non-medical, evidence-based services for high-risk health plan members. Services address housing, interpersonal safety, food, and transportation to improve member health and well-being. To qualify, individuals must:

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

Although Vaya determines who qualifies for the Healthy Opportunities pilot, TCM providers are responsible for the following responsibilities for participating members:

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

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

For additional information about the Healthy Opportunities Pilots, including specific services available, visit https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots.

Network Provider Coordination Responsibilities

Vaya contracts with institutions in the Tailored Plan provider network (hospitals, residential settings, rehabilitation settings, State Operated Health Care Facilities, ICF-IIDs, other facility-based treatment settings and LTSS providers) to establish policies and procedures for care transitions. Network Providers must fully cooperate with organizations providing Tailored Care Management (TCM) and integrated care activities, including, but not limited to, the following:

- Actively participate in interdisciplinary team meetings convened or arranged by the TCM and/or include the TCM in team meetings convened or arranged by you.
- Provide at least 24 hours prior notice to the TCM of the date, time and place of any treatment team or discharge planning meeting involving a member with an assigned TCM.
- Provide accurate and timely information to the TCM regarding the member's participation in treatment and clinical progress.
- Work with the TCM and child and family or adult planning team in developing an appropriate, whole-person plan of care (care plan or person-centered plan), including crisis planning for individuals regardless of disability type. Treatment plans must address MH, SUD/addiction, I/DD, medical, dental and specialty needs, as well as include evidence of medication reconciliation across all care providers and a detailed, cross-system CCP using evaluations, assessments and collateral information.
- Develop and implement treatment and/or supports strategies to address assigned areas of responsibility from the Care Plan.
- Develop step-down and discharge plans within the first month of admission.
- Take the primary role in 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 Tailored Care Management (if applicable) to integrate the organization into the discharge/transition planning process.
- Share relevant information (including the member's current Care Plan/ISP, initial and final discharge plans, and medical information when applicable) among transition/discharge planning team members and the member's care team if applicable.
- Establish relationships with AMH+ practices and CMAs to facilitate care transitions.

- Notify the assigned TCM whenever a member receiving TCM services is admitted to an ED, FBC or inpatient unit.
- Provide accurate information to members and their families regarding clinical coverage policies and levels of care that are typically most effective at treating or supporting a member's treatment or habilitative needs and helping a member and his or her family plan for multiple treatment options.
- Complete, timely and accurately, all appropriate or required level of care/clinical decision support tools identified in Section 3 of this Manual, including, but not limited to, CANS-MH, NC-SNAP, SIS® and ASAM placement criteria.
- Work with Vaya's transition team, TCM organization, primary care providers and other Vaya-contracted providers regarding a member's medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem-solving, as well as identification of medical home for persons in need.
- Follow the process for admissions to a State Developmental Centers. Any application for a State Developmental Center must be coordinated with Vaya because we are responsible for ensuring all DSOHF admission criteria and protocols are met. The member/ LRP or Network Provider must provide Vaya with all information necessary to determine if application to a State Developmental Center should be made and for a complete admission packet to be submitted. Assigned I/DD TCMs and our I/DD Transition Coordinator will review the application to ensure all other reasonable lower levels of care were exhausted first. Vaya must provide a letter of support to the DSOHF for an application to be accepted. Individuals accepted into a State Developmental Center will be followed by the I/DD Transition Coordinator through discharge. **State Developmental Centers are not considered long-term or lifetime residential placements,** and individuals must be reviewed quarterly for discharge consideration. Each member accepted for admission to a State Developmental Center will be accepted only under a MOA for one year. All individuals will be discharged the date stated on the MOA. Vaya will ensure timely execution of the MOA with the member's guardian regarding the member's discharge plan.
- If the member has a BH home and receives services that include certain care coordination, care management or case management activities per the applicable NC Medicaid Clinical Coverage Policy, DMH/DD/SAS state services definition or the Network Provider's contract with Vaya, the BH 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 assigned TCM may result in a referral for investigation and may lead to administrative action or sanction, up to and including termination of contract. In cases in which there is not an identified BH Home, the assigned TCM will provide certain TCM activities and functions outlined in Vaya's contracts with DHB and DMH/DD/SAS based on the population served.

In-reach: Transitions to Community Living Initiative (TCLI)

Vaya Health administers the Department's Transitions to Community Living Initiative (TCLI) program in our service area. TCLI gives eligible adults (18 years or older) with serious mental illness (SMI) or serious 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 home and community of their choice. TCLI stems from a 2012 settlement agreement between the State of North Carolina and the U.S. Department of Justice. The TCLI Team is a specialty CCM team that serves eligible TCLI participants and links them with wraparound mental health and other support services that help them live in a home rather than a facility.

TCLI allows eligible individuals to engage in leased housing, learn everyday skills, take part in community activities, and develop lasting relationships. Participants receive behavioral health services, employment assistance and help becoming part of the community. Through job skills and employment programs, people identify their interests and prepare to find a job in a competitive workplace. Vaya's TCLI program focuses on six areas:

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

What is the process if a Network Provider would like a member to be considered for TCLI?

Members who are eligible for TCLI consideration must meet specific criteria for referral (formerly PASRR; currently RSVP). This referral is made online at https://www.socialserve.com/nc/rsvp.If the individual has a guardian that is considered a "guardian of the person or general guardian" but NOT the "guardian of the estate," that guardian MUST be notified BEFORE making the referral.

- Members must be at risk for admission into an ACH or other adult living facility.
- Members must have a SMI/SPMI diagnosis; and may have other co-occurring MH/ SU/BH needs.
- Members must be eligible for Medicaid in North Carolina.
- Members must have an income of $2,000 or below.
- Members must be 18 years old and willing to accept a minimum of one tenancy support per month.

If you are working with a member who you would like to refer for consideration into TCLI, please complete an RSVP Referral. Referrals will be screened by Vaya's Member Services department within 30 – 45 days.

What is the process if a Network Provider is working with a member who is not yet housed, but involved with TCLI?

The preliminary visits for TCLI begin with In Reach staff and ongoing assessment of housing needs, mental health supports, and supported employment options. During this time, it is important that Network Providers support the member and the In-Reach staff with honesty of needs, historical obstacles, and future goals and strengths. The Network Provider should begin collaborating with the assigned TCLI staff to continue options counseling to

reach the goal of identifying and moving the member into supportive, independent living. Network Providers should attend meetings (as needed), complete and produce all supporting verification documentation, assist with identifying housing, and assist with the move.

What is the process if a Network Provider is working with a member who is already housed with TCLI?

The primary role of the Network Provider in working with a member who has been housed as part of TCLI is to help the member maintain housing by providing tenancy supports and ensuring that the member integrates into their community, creating a meaningful day. Cleanliness, safety and security, visitor management, medication routines, and lease obligations should be practiced and enacted. Tenancy Support providers must provide a monthly update to the Transition Coordinator about the member and alert the Transition Coordinator to all significant housing or health-related events, including but are not limited to: member is hospitalized, experiences a serious illness or new diagnosis, has lost housing, is homeless, has incurred a lease violation(s), has unpaid bills that could result in loss of lease, has law enforcement or other legal interactions, or has been in elopement or unaccounted for more than 72 hours.

What if the member is losing housing or at risk of losing housing?

If the member is at risk of losing housing or losing housing, please convene a team meeting and include the Transition Coordinator in eviction avoidance planning. Network Providers are responsible for partnering with TCLI staff to help resolve and prevent disputes between landlords and TCLI participants that could lead to eviction.

Are there any requirements for Network Providers related to Supported Employment?

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

For providers who are contracted to provide SE or ACTT services, you must provide SE program data that includes member development/phase of service (i.e., job development, creation of small business/micro-enterprise, placement or LTVS) and outcomes, including the number of individuals who obtained jobs, the member's start date, hours worked, wages, benefits, and pertinent employer information. Reporting must be submitted electronically on a quarterly basis to Vaya via email at: SupportedEmployment@vayahealth.com.

HOUSING SUPPORTS

Vaya believes that having a safe and stable place to live is an integral part of wellbeing and recovery. One of the primary barriers that prevents members from remaining stable and avoiding a crisis is lack of housing. **Housing supports are not an entitlement, and funds are limited.**

Network Providers are required to collaborate with Vaya's housing efforts and must:

- Participate in or refer landlords and other stakeholders to Vaya's housing initiatives.
- Assist members as needed to remain stably housed.

- For providers who are contracted to provide State-Funded Residential Services (SFRS):
  - Maintain a current list of members for whom the agency is receiving SFRS funding.
  - Submit Unused Bed Day Census reports monthly.
  - Notify Vaya of vacancies within one day.
  - Follow guidelines for the SFRS referral process.
- For providers who signed a Memorandum of Agreement (MOA) to make referrals into the Permanent Supportive Housing (PSH) Program:
  - Provide ongoing services to PSH referred participants as needed and provide monthly reports of those services.
  - Communicate regularly with the housing coordinator when changes occur, such as the participant's stability, income, household composition, etc.

Transitional Care Management

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

As part of transitional care management, there should be a systematic, clinically appropriate process with designated staffing for care managers responding to certain situations such as high-risk Admission, Discharge, Transfer alerts (e.g., related to a visit to the Emergency Department or hospital). Vaya will ensure that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period.

Transitional care management responses should include the following:

- Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up.
- Same-day or next-day outreach for designated high-risk subsets of the population.
- Additional outreach within several days after the alert to address outpatient needs or prevent future problems for patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

Diversion from Institutional Settings

Tailored Care Management organizations also provide diversion interventions to members who are identified as at risk of requiring care in an institutional setting or ACH.

ELIGIBILITY FOR DIVERSION

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

1. Have transitioned from an institutional or correctional setting, or an ACH for adult members, within the previous six (6) months; or
   a. Are seeking entry into an institutional setting or ACH; or

   b. Meet one of the following additional criteria for members with I/DD or TBI:
2. Member has an aging caregiver who may be unable to provide the recipient their required interventions; or
3. Member's caregiver is in fragile health, which may include but is not limited to member caregivers who have been hospitalized in the previous twelve (12) to eighteen (18) months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.); or
4. Member with two parents or guardians if one of those parents/guardians dies; or
5. Any other indications that a member's caregiver may be unable to provide the member their required interventions; or
6. Member is a child or youth with complex BH needs.

DIVERSION ACTIVITIES

The assigned organization providing Tailored Care Management performs the following diversion activities in a timely manner:

- Screen and assess the member for eligibility for community-based services.
- Educate the member on the choice to remain in the community and the services that would be available to support that decision.
- Facilitate referral and linkages to community-based and other support services for assistance.
- Determine if the member is eligible for supportive housing, if needed.
- For those who choose to remain in the community:
    - Develop a Community Integration Plan (CIP) that clearly documents that the member's decision to remain in the community was based on informed choice, and the degree to which the member's decision has been implemented.
    - Integrate the member's CIP as an addendum in the member's Care Plan or ISP.
    - For members with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.

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

DATA SYSTEMS AND DATA SHARING IN SUPPORT OF TAILORED CARE MANAGEMENT

Vaya will ensure that organizations providing Tailored Care Management have access to an Admission, Discharge, Transfer data source (e.g., that identifies when a member is admitted, discharged, or transferred to/from an ED or hospital in real or near real time). Following TCM assignment, Vaya will share with AMH+ practices, CMAs, CINs, or other partners the following data elements to support Tailored Care Management:

- Clinically relevant and available enrollment/eligibility data
- Point-in-time assignment information on at least a monthly basis
- Projected assignment information for the following month (to the extent information is available)
- Information about newly assigned members to the BH I/DD Tailored Plan, within seven business days of enrollment
- Notifications of any ad hoc changes in assignment as they occur, within seven business days of each change
- Acuity tiering results for every assigned member and any changes to a member's acuity tier assignment (shared within seven business days of each update)

- (If/when risk stratification is employed by Vaya) additional risk scoring results for every assigned member, including (where possible and relevant) member-level information about cost and utilization outliers
- (If/when risk stratification is employed by Vaya) when feasible, types or categories of risk stratification model inputs (e.g., frequency of hospital utilization) and clinically relevant information identified through the risk score development process that can inform specific actions by the AMH+ practice or CMA.

Duplication of Care Management

Organizations providing Tailored Care Management shall coordinate with other Care Management Programs to ensure that care management is not duplicated and to ensure a smooth transition when members transition to or from Tailored Care Management. Other care management programs duplicative of Tailored Care Management include Care Management for At Risk Children (CMARC) and Care Management for High-Risk Pregnancy (CMHRP) provided by local health departments, Pregnancy Management Programs, case management provided through Assertive Community Treatment (ACT) and ICF-IIDs and care management provided through the High-Fidelity Wraparound (HFW) program. When a member is receiving a service other than those listed above that has potential for duplication with Tailored Care Management, the care manager and the provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the Care Plan to avoid duplication of services. Providers delivering services duplicative of care management must notify Vaya within 45 days of a member transitioning into or out of the service.

HIGH FIDELITY WRAP AROUND (HFW) PROVIDERS

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

MEMBERS OBTAINING ACT, RESIDING IN AN ICF-IID, OR NURSING FACILITY

Vaya will implement the following protocols for members obtaining ACT or services in an ICF-IID, or members residing in a nursing facility for a period of ninety (90) days or longer:

- Ensure that members who were engaged in TCM prior to obtaining ACT, will receive transitional care management in the first month of obtaining ACT. Vaya will also ensure that during the members last month of obtaining ACT, the member will be assigned to an organization for TCM and receive transitional care management.
- Ensure that members who were engaged in TCM prior to obtaining services in an ICF-IID, will receive transitional care management in the first month of obtaining services in an ICF-IID. Vaya will also ensure that during the members last month of obtaining ICF services, the member will be assigned to an organization for TCM and receive transitional care management.
- Ensure that members who were engaged in TCM prior to obtaining services in a nursing facility, will receive transitional care management in the first month of obtaining nursing facility services. Vaya will also ensure

that for members who are eligible for and part of a priority population for TCM, the member will be assigned to an organization for TCM and receive transitional care management during the last of month of obtaining nursing services. For members who have BH needs but are not eligible for or not part of a priority population for TCM, Vaya will ensure that the member receives care coordination for a BH transitional care need, in the last month of obtaining services through a nursing facility.

- Suspend enrollment in TCM effective the month following initial receipt of ACT or ICF-IID services and report the suspension to the Department.
- Deny claims submitted by providers for TCM except in the first or last month of the member obtaining ACT, residing in an ICF-IID, or residing in a nursing facility
- Ensure that when a member begins obtaining ACT or services through an ICF-IID or nursing facility, the member's care manager for TCM shares the member's Care Plan/ISP with the ACT, ICF-IID, or nursing facility case manager, as lawful with consent.

Care management functions may be provided by a BH clinician who specializes in the needs of members with MH/IDD/SU diagnoses, QPs with MH/IDD/SUD specialties, RN care managers who specialize in medically complex or medically fragile service needs, IDD QP care managers and/or certified peer support specialists (PSS). CMs may directly perform an identified task or follow up to ensure that tasks are completed by a member of the interdisciplinary, multisystem and support care team (ICT), which includes the behavioral health provider. Care decisions are driven by what is best for the member based on ethical and best practice, not the convenience of the provider or caregiver/ LRP. Vaya's CCM practices include, but are not limited to, assessment, care plan development, crisis plan development, tasks and interventions, referral and linkage, risk and disease management and monitoring. CCM processes also address the following:

1. **Team Structure:** The CM is part of the ICT that consists of the member/ LRP and anyone they choose/ allow, including but not limited to the behavioral health provider, primary care provider, and in consultation with any specialists caring for the member.
2. **Scheduling:** Team meetings may convene electronically, telephonically or in person and target the goals of the plan of care. CCM staff make reasonable accommodations to meet (telephonically or in-person) at times and locations convenient to the member/ LRP and their family based on acuity and member care needs. Times set for meetings should be based on legitimate scheduling challenges for a member or their supports. For example, if a member or LRP works regular business hours Monday through Friday, it is reasonable for the CM to meet with the member after regular business hours during the week or a weekend day if requested. However, this flexibility is not an entitlement when a member and their ICT can meet within regular business hours.
3. **Safety:** If the member's or natural support's behavior or home environment presents a risk to the health, safety, or wellbeing of the assigned CM, Vaya reserves the right to hold meetings in a neutral location, such as the Network Provider's office and/or include a CC manager in the meeting. Dangerous home environments include locations where unsecured or illegal weapons, illegal substances or dangerous animals are present. We will not tolerate physical, emotional, or verbal abuse of Vaya staff by members, natural supports, or Network Providers. This includes, but is not limited to, profanity, yelling, disrespect, inappropriate physical interactions, or violations of personal space. In such cases, we reserve the right to immediately terminate the meeting or telephone call and report such behavior to the Network Provider or NPI Department for investigation.
4. **Social Determinants of Health.** Vaya recognizes that SDoH are the primary driver of health disparities, and that a member who lacks stable housing and is unemployed or under-employed will have increased risk factors related to poverty, potential trauma exposure, stress, and difficulty in accessing appropriate

medications, preventive care or engaging in therapy. Within available resources, CMs may work with a member to improve or obtain adequate living conditions, education or employment, nutrition, engage in healthy activities and/or address transportation needs.

5. **Crisis Response:** TCM is not a crisis intervention. In cases where a member has an existing treatment relationship, the provider should be the initial crisis contact. However, providers should notify the assigned CM if a member experiences a crisis so that the TCM can evaluate, in collaboration with the ICT, what additional service needs and crisis plan adjustments are needed once the member's crisis has been addressed. CMs are responsible for ensuring continuity of care to the degree possible in cases of local disasters or emergencies.

Vaya Complex Care Management Teams

Team	Description
MHSU Tailored Care Managers	This team provides all responsibilities of Tailored Care Management for members who's assigned TCM agency is Vaya Health. MHSU Care Managers operate under a person-centered, recovery-focused model and serve as the help members who may need health and social support. They ensure an integrated, whole-person care approach and foster coordination and collaboration among care team members across disciplines and settings.
I/DD Tailored Care Managers	This team provides all responsibilities of Tailored Care Management for members who's assigned TCM agency is Vaya Health. I/DD Care Managers operate under a person-centered, recovery-focused model and serve as the help members who may need health and social support. They ensure an integrated, whole-person care approach and foster coordination and collaboration among care team members across disciplines and settings. I/DD Care Managers also perform the following care coordination activities in accordance with Waiver requirements: (1) assisting in the development of a Care Plan for each Innovations Waiver participant/Member; (2) monitoring the provision of services to the Member; and (3) ensuring the Member's health and safety needs are met, that services and supports are provided in the most integrated setting, and that the Member is satisfied with the services and supports they are receiving.
Tailored Care Management Registered Nurse (RN) Staff	The RN hosts routine huddles for the clinical pods which serve as a clinical staffing model to provide consultation to priority members. Priority members will receive RN clinical evaluation, PharmD, and MD consultation based on specific factors that will be determined by Vaya's medical team. The RN role within the member care team shifts based on member needs and they may play a more prominent role following medical or psychiatric inpatient transition and then step into a more consultative role in support of the identified primary Care Manager.

Team	Description
Acute Transitional Care Managers and Admission Through Discharge Managers	This team provides on-site transition planning from psychiatric inpatient settings for Vaya members, ensuring coordination with both Vaya's community based Tailored Care Management teams and outside community services and supports. These team members are embedded within private community hospitals, some EDs, and DSOHF sites. This team reports to an RN and consists of licensed BH clinicians and qualified professionals supports various transition types, and partners with care managers and transition care managers embedded within AMH+s, CINs, and CMAs.
Housing Supports Team (HST)	This team supports members and recipients to secure housing resources; manage resources; and work with community partners to provide safe and stable living situations to support well-being, recovery, and reduce crisis events. The HST works with providers, members, and community partners to provide knowledge, resources, and training about housing and residential options, striving to increase partnerships with affordable housing providers and improving quality of life for individuals who qualify for specialty housing programs administered by Vaya. As a BH I/DD Tailored Plan, much of the HST's functions will remain. Housing Specialists will be part of the CM pods described above to ensure members in care management have access to housing supports. The HST develops and maintenance of the Regional Housing Plan in concert with the Statewide Housing Plan and are experts on supportive housing for members and organizations providing Tailored Care Management.
I/DD In Reach & Transition Coordination Team	This team works with State Developmental Centers, State psychiatric hospitals, Skilled Nursing Facilities, and ICF-IID homes to identify and support members who would like the opportunity to return to their communities with the right supports and services. performs the In Reach, Transition Coordination and Admission Through Discharge functions. I/DD Transition Coordinators conduct Transition Coordination for members residing in DSOHF Developmental Centers. They perform In Reach for members residing in DSOHF Developmental Centers and transitions from community-based ICF-IID. The In Reach-Community ICF-IID staff conduct In Reach for members residing in community-based ICF-IIDs. When a resident is identified for transition, the In Reach-Community ICF-IID staff will facilitate a warm hand-off to an I/DD Transition Coordinator.
Transition Coordination & Peer Support Team	The team links eligible participants with wraparound BH, medical, and other support services that help them live in a home of their own rather than in an Adult Care Home (ACH) or other institution. This team is supervised by a licensed MH/SU I/DD Director and has two sub-teams: In-Reach and Transition Coordination. This team provides Peer Support and Transition Coordination from DSOHF Psychiatric Hospitals and Adult Care Homes as well as Diversion for eligible State Funded recipients.

Team	Description
Geriatric and Adult Mental Health Specialty Team (GAMHST)	The GAMHS Team, including RNs, licensed BH clinicians, and qualified professionals, provides education and support opportunities to professional staff, family caregivers and other individuals who care for or work with adults ages 60 years and older experiencing dementia or other BH concerns within the Vaya service area. The team also serves caregivers of younger adults with a dementia diagnosis. The team offers free education and support for professional staff and family caregivers within available resources. For professionals, the program offers contact hours approved by the N.C. Division of Health Service Regulation (DHSR). Providers are encouraged to make referrals to GAMHST for caregivers of individuals aged 60 and older who are experiencing mental illness, substance use, dementia, or emotional/ behavioral challenges to enhance caregiver's skills, knowledge, and awareness of resources. The GAMHST referral form can be found at https://providers.vayahealth.com, and questions can be emailed to Geriatric.Team@vayahealth.com.
SUPPORTS INTENSITY SCALE® (SIS®) Assessment Team	Using wraparound supports, the Olmstead Team supports members transitioning from long-term institutional care to a home of their choosing. SIS® Assessment Team members are certified through the American Association on Intellectual and Developmental Disabilities (AAIDD) to provide standardized assessments to members participating in the Innovations Waiver. Effective November 1, 2016, all Innovations Waiver participants must have a valid (performed within the last three years) SIS® score in place as part of the annual plan of care approval process.

Calculating TCM Program Costs and Outcomes

COSTS

Methodology for determining TCM program costs includes identifying, tracking, and reporting both specific direct and indirect costs. Costs include provider payments and Vaya's internal expenses to administer and deliver TCM.

Providers payments are processed based on the content of claims submitted to Vaya. The Vaya MCIS and data warehouse sort billed services into appropriate expense and funding categories based on member enrollment status, diagnosis, and procedure code. Claims system information then imports into an accounting system that tracks costs by funding sources, such as Medicaid, Single Stream, non-UCR, and UCR. Provider payments are classified to the TCM program based on the definitions of eligible payments.

Vaya's internal expenses are grouped generally as administrative expenses and classified as either direct or indirect. Direct expenses are clearly linked to a specific purpose, such as a care manager performing TCM activities. Expenses that are 100% associated with TCM are coded by the accounting system for identification and reporting.

Indirect TCM expenses support multiple Vaya organizational functions and fall into two allocation pools:

1. Indirect costs that have a direct relationship to TCM but are not 100% dedicated to the program; and
2. Indirect costs for corporate overhead functions (such as finance, legal, and executive) that support the entire organization.

For each allocation pool, Vaya calculates indirect costs based on actual direct TCM expenses as a portion of the total direct expenses for non-TCM expenses.

OUTCOMES

Vaya prioritizes an evaluative multi-faceted approach to identifying and assessing TCM outcomes. The evaluation includes but is not limited to the following:

- Tailored Plan contractual requirement data, including Tailored Plan quality outcomes and Tailored Plan required reports.
- Identification and monitoring of changes in TCM activities, including core TCM quality measures, potential performance differences by type of TCM provider, and any trends that suggest a qualitative "deeper dive" would be beneficial to explore/confirm root causes, opportunities for improvement, ways to help build capacity among providers, identify data or reporting errors, cross-validate existing data, and streamline communication and coordination.
- Analysis for potential associations among variables, such as health outcomes; service utilization patterns; health care costs; programmatic costs; differences across subpopulations, including populations at risk of greater health disparities and those with unmet health-related resource needs; level/intensity/duration of TCM; timely completion of assessments, care plans and care transitions; primary disability type; and acuity level and/or other risk stratification and predictive analytics indicators.
- Additional data sources:
    - Internal operational reports and dashboards, including process outcomes and interim measures.
    - Qualitative data and feedback from stakeholders and providers.
    - Information from internally generated process improvements and from formal quality improvement activities (QIAs), quality improvement projects (QIPs), and performance improvement plans (PIPs).
    - Results of value-based purchasing and contracting initiatives

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SECTION 5 | Provider Responsibilities

Provider Preventable Conditions

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

Records Retention

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

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

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

Documentation and Clinical Coverage Policy Requirements

All Vaya Network Providers are required to strictly adhere to the documentation requirements outlined in the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Medicaid service provision requirements are specified in Clinical Coverage Policies (CCPs) promulgated by DHB. Many of the CCPs also include specific documentation, training and other requirements. It is the responsibility of each provider to be familiar with and follow CCP requirements. Unfortunately, Vaya monitoring activities have identified trends of non-compliance with respect to the following. Please ensure that you and your staff understand and comply with these requirements, as applicable to your delivery of services:

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

Compliance

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

- Title XIX of the Social Security Act (the "Act") and its implementing regulations, including those set forth at 42 CFR Parts 438, 441, 455 and 456 concerning care coordination, access to care, utilization review, clinical studies, utilization management, care management, quality management and disclosure requirements.
- The N.C. State Plan for Medical Assistance

- The N.C. combined Medicaid Waiver authorized by CMS pursuant to sections 1915(b) and 1915(c) of the Act
- All federal and state civil and criminal laws, rules and regulations governing the provision of publicly funded health care services
- The Anti-Kickback Law codified at 42 U.S.C. § 1320a-7b(b) and its implementing regulations
- The Ethics in Patient Referral Act, 42 U.S.C. § 1395nn and its implementing regulations (applicable only to physicians)
- The federal False Claims Act, 31 U.S.C. §§ 3729 – 3733 and its implementing regulations
- The N.C. Medical Providers False Claims Act, N.C.G.S. § 108A-70-10 et seq.
- Applicable provisions of N.C.G.S. Chapters 108A, 108D, 122C, 131D and 131E
- All federal and state member rights and confidentiality laws, rules and regulations, including, but not limited to:
    - N.C.G.S. §§ 122C-52 through 56
    - The N.C. Identity Theft Protection Act, N.C.G.S. §§ 75-61 et seq.
    - The DMH/DD/SAS Client Rights Rules in Community Mental Health, Developmental Disabilities and Substance Abuse Services, APSM 95-2
    - The DMH/DD/SAS Confidentiality Rules, APSM 45-1
    - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations at 45 CFR Parts 160, 162, and 164
    - Confidentiality of Substance Use Disorder Patient Records laws and regulations codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2
- Medical and/or clinical coverage policies promulgated by NCDHHS in accordance with N.C.G.S. § 108A-54.2
- The Americans With Disabilities Act of 1990
- Titles VI and VII of the Civil Rights Act of 1964
- Section 503 and 504 of the Vocational Rehabilitation Act of 1973
- The Age Discrimination Act of 1975
- The Drug Free Workplace Act of 1988
- State licensure, accreditation and certification laws, rules and regulations applicable to your operations
- DMH/DD/SAS Rules for MH/DD/SA Facilities and Services, published as APSM 30-1 and codified at Title 10A of the North Carolina Administrative Code
- DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2
- The Record Retention and Disposition Schedule for DMH/DD/SAS Provider Agencies, APSM 10-5
- The Records Retention and Disposition Schedule for State and Area Facilities, APSM 10-3
- The NCDHHS Records Retention and Disposition Schedule for Grants
- This Vaya Health Provider Operations Manual
- Any other applicable federal or state laws, rules, or regulations in effect at the time behavioral health and/or I/DD services are rendered to Vaya Health Plan members

COMPLIANCE PROGRAM

The Patient Protection and Affordable Care Act requires all healthcare providers to establish and implement a compliance program that meets the requirements of 42 C.F.R. § 438.608, as well as policies and procedures that meet the requirements of the Deficit Reduction Act of 2005. You must develop a formal Compliance Plan that includes procedures designed to guard against fraud and abuse. The plan should include the following elements, at a minimum:

- An internal audit process to verify that services billed were furnished by appropriately credentialed staff and appropriately documented

- Assurance that staff performing services under your contract with Vaya are not excluded from participation in federal health care programs under either Section 1128 or 1128A of the Social Security Act
- Written policies, procedures and standards of conduct that articulate your commitment to comply with the Controlling Authority listed above
- Designation of a compliance officer and compliance committee
- A training program for the compliance officer and organization employees
- Well-publicized systems or mechanisms for reporting suspected fraud and abuse by employees and members and protections for those reporting
- Provisions for internal monitoring and auditing
- Procedure for response to detected offenses and for the development of corrective action plans
- Reporting to oversight and law enforcement agencies, including Vaya

For more information and guidance about your compliance responsibilities as a healthcare provider that accepts public funding, please refer to the U.S. Health and Human Services' Office of Inspector General Compliance Resource Portal page at: https://oig.hhs.gov/compliance/compliance-resource-portal.

Vaya develops and maintains a written Compliance Plan that includes the OIG "Seven Effective Elements" and is approved by the Vaya Board of Directors. We have a designated Compliance Officer and Vaya Compliance Committee that are accountable to senior management, as well as procedures to ensure the compliance of Vaya and the Provider Network, including the establishment of monitoring and auditing systems that are reasonably designed to detect conduct in violation of applicable federal and state laws, rules, regulations, guidelines, policies and standards.

Disaster and Emergency Relief Planning and Response

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

Vaya's community disaster response coordinator will participate in the development of community disaster emergency response plans, collaborate with other state vendors to align efforts, promote recruitment and training of network Medicaid and State-funded behavioral health providers to staff disaster shelters, and respond to resource requests from the Division of Emergency Management within the North Carolina Department of Public Safety. Upon notification and activation of a community disaster, if needed, the vice president of provider network operations or designee will begin coordination and engagement activities with local providers.

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

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

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

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

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

Abuse, Neglect, and Exploitation

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

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

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

Provider Exploitation and Boundary Issues

10A NCAC 27C .0102 defines exploitation as the “use of a client’s person or property for another’s profit or advantage.” In keeping with this definition, Vaya considers provider exploitation to be the illegal or improper act of

using a Vaya Health Plan member or their resources for monetary or personal benefit, profit or gain, by a Network Provider (including its owners, employees, agents or contractors). Examples include, but are not limited to:

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

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

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

Vaya recognizes that the vast majority of our providers are dedicated, caring, principled and extraordinarily kind people who would never knowingly exploit or confuse our members. Our expectation is that Network Providers will use good judgment, consistent with current ethical standards and licensure rules, to make appropriate decisions that avoid the potential for exploitation or boundary confusion.

NOTE: Some information in this section was taken from "Managing Boundaries and Dual Relationships" by Frederic G. Reamer, PhD, March 4, 2002, *Social Work Today*, https://www.socialworktoday.com/news/eoe_030402.shtml.

Health Information Technology and Security

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

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

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

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

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

ELECTRONIC VISIT VERIFICATION (EVV)

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

Electronic Visit Verification is a system that uses technology to record and confirm information about the delivery of services. This system uses time, date and location information from a cell phone, a home phone (land line) or an electronic fob to verify that Medicaid services authorized and reimbursed by Vaya Health are delivered to our members.

Vaya, along with all other North Carolina LME/MCOs, has selected HHAeXchange as our EVV vendor. Specifically, for current LME/MCO-covered services, EVV requirements apply to Community Living and Supports (CLS) and Supported Living-Periodic services provided under the Innovations Waiver and with (b)(3) funds, as well as the following additional (b)(3) services: Personal Care/Individual Supports; Transitional Living Skills; and In-Home Skill Building.

As a BH I/DD Tailored Plan Vaya must utilize an EVV system 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 21st Century CURES Act, 114 U.S.C. § 255:

- Type of service performed;
- Individual receiving the service;
- Date of the service;

- Time that the service begins;
- Location of service delivery;
- Individual providing the service; and
- Time that service ends

Health Information Exchange

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

Originally, the legislation required that all providers of "services rendered to Medicaid and other State-funded health care program beneficiaries" must be connected to the HIE by specific deadlines to continue to receive payment with "Medicaid or other State-funded health care funds." However, N.C. Session Law 2019-23 (HB 70) established those certain providers of Medicaid or State-funded health care services "are not required to connect to the HIE Network or submit data but may connect to the HIE Network and submit data voluntarily". These providers include:

1. Community-based long-term services and supports providers, including personal care services, private duty nursing, home health, and hospice care providers.
2. Intellectual and developmental disability services and supports providers, such as day supports and supported living providers.
3. Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.
4. Eye and vision services providers.
5. Speech, language, and hearing services providers.
6. Occupational and physical therapy providers.
7. Durable medical equipment providers.
8. Nonemergency medical transportation service providers.
9. Ambulance (emergency medical transportation service) providers.
10. Local education agencies and school-based health providers.

Under this Session Law, the NCDHHS Secretary is also authorized to grant exemptions to additional classes of providers, "for whom acquiring and implementing an electronic health record system and connecting to the HIE Network … would constitute an undue hardship." **Except as otherwise provided in the legislation, all other providers of Medicaid and State-funded health care services must be connected to the HIE and shall begin submitting demographic and clinical data by June 1, 2020.** However, the Department is authorized to grant extensions of time to the deadline "upon the request of a provider or entity that demonstrates an ongoing good-faith effort to take necessary steps to establish such connection and begin data submission." No exemption or extension shall extend beyond December 31, 2022, except for the voluntary provider types listed above.

For more information about the HIE, please refer to https://hiea.nc.gov.

Emergency Services and Hospital Requirements

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

EMERGENCY AND CRISIS STABILIZATION SERVICES

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

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

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

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

EMERGENCY DEPARTMENT ADMISSION FOR BEHAVIORAL HEALTH CRISIS NOTIFICATION

If a member of a Vaya Health Plan, or someone who you believe may be eligible for a Vaya Health Plan, presents at an ED or FBC in a behavioral health crisis, the facility must inform Vaya of the admission via a daily report to their designated Vaya point of contact and/or by calling the Provider Support Service Line at 1-866-990-9712. The hospital ED or facility where the individual is receiving treatment is ultimately responsible for assessment and disposition of individuals in their care. However, Vaya’s Acute Care Response Team is available to provide ED and FBC staff with consultation, coordination with the individual’s BHCH and education on possible resources for appropriate treatment.

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

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

INPATIENT ADMISSION NOTIFICATION AND AUTHORIZATION OF STAY

Behavioral Health Admissions:

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

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

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

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

All Other Admissions:

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

CRITERION V REVIEWS

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

RETROSPECTIVE AUTHORIZATION

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

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

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

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

Involuntary Commitment

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

INVOLUNTARY COMMITMENT PROCESS

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

Who can file a petition for involuntary commitment?

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

What are the criteria for involuntary commitment?

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

What should the petition include?

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

Where, how and when is the petition filed?

Every county has its own procedure, so it is important to check with the Clerk of Court's office where the petition is to be filed before initiating the process. The petition must be filed in the county where the individual resides. IVC petitions are generally taken out with the Clerk of Court or local magistrate. In some counties, only the magistrate can accept an IVC petition. The petition can be filed at any time, including after regular business hours.

After-hours petitions are always taken out with the local magistrate. Contact information for Clerks of Court and magistrate's offices are available on county websites and through the Administrative Office of the Courts: at https://www.nccourts.gov/locations.

What happens if the IVC petition is accepted?

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

What happens after the individual is picked up by law enforcement?

The individual must receive an evaluation from a "first evaluator" within 24 hours of presentation to the facility. The first evaluator can be a physician, psychiatrist, eligible psychologist or Certified First Evaluator or First Commitment Evaluator (certified through a rigorous process – LCSW, LCAS with limitations or psychiatric NP). The

first evaluator can do one of the following: (1) stop the process and release the respondent if he or she determines the individual does not meet IVC criteria; (2) recommend inpatient mental health commitment; (3) recommend outpatient MH commitment; or (4) recommend substance abuse (SA) commitment.

If recommending SA commitment, the first evaluator can release the respondent pending a hearing and refer him or her to an outpatient provider, or the first evaluator can hold the respondent at a 24-hour facility pending a court hearing (a 24-hour treatment facility must be named on the form and accept the respondent). The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using Form 572: Examination and Recommendation to Determine Necessity for Involuntary Commitment.

What happens if the first evaluator recommends inpatient commitment?

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

- If seven days pass, the commitment process is terminated at that time or can be restarted with a new petition. If a doctor or an eligible psychologist is new petitioner, the doctor or psychologist must conduct a new examination and may not rely upon the prior examination.
- The interim evaluation cannot be performed by other mental health professionals who perform initial examinations under the Waiver. The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using Form 572: Examination and Recommendation to Determine Necessity for Involuntary Commitment, as well as a Notice of Commitment Change Form.

What happens when a 24-hour facility is located?

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

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

If the respondent is released, he or she is returned home via law enforcement or may arrange his or her own transportation. **Network Providers may not decline inpatient admission based on an individual's transportation options post-discharge.**

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

The 24-hour facility sends the petition and paperwork to the Clerk of Court in the county where the facility is located. A District Court hearing must be held within 10 days of an individual being taken into custody by law enforcement. If the court finds by clear, cogent and convincing evidence that the individual meets inpatient

mental health commitment criteria, it may order inpatient commitment for up to 90 days at the initial hearing, a maximum of 180 days at the first rehearing and a maximum 365 days at second or subsequent rehearing. Commitment can be inpatient, outpatient or a combination of the two.

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

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

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

- The first evaluator must complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment Form, check all appropriate OPC boxes in all sections and identify the name and address of the proposed outpatient treatment provider using Form 572.
- The first evaluator must also give the member an appointment time and date for the follow-up examination with the outpatient treatment provider.
- The initial petition and the first evaluation must be returned to the Clerk of Court prior to the follow-up appointment with the proposed provider.
- The Clerk of Court will schedule a hearing and notify the respondent and the proposed outpatient treatment center of the hearing date.
- If the member fails to show for the follow-up OPC appointment, the proposed provider must attempt follow up and, if that fails, may file a Request for Transportation Order and Order (Outpatient Fails to Appear for Pre-hearing Examination AOC-SP-224), available at: http://www.nccourts.org/Forms/Documents/853.pdf.
- The proposed provider's MD or licensed psychologist must complete another examination to determine if the individual continues to meet the criteria for OPC.
- If the member is still in need of an OPC, the proposed provider's MD, licensed psychologist or designated clinician will attend the OPC hearing, where the judge will decide whether to continue the OPC. In some instances, the judge may order the examining MD or licensed psychologist to provide face-to-face testimony at the OPC hearing. This OPC hearing is held within 10 days of the initial MD's evaluation.
- If the individual appears for the follow-up examination appointment and no longer meets the criteria for OPC, the MD or licensed psychologist should complete the Notice of Commitment Change Form and send to the Clerk of Court, with a copy to the assigned Vaya care manager. This form is available at: https://www.ncdhhs.gov/ivc.

OUTPATIENT COMMITMENT RESPONSIBILITIES

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

Outpatient Commitment to members who are respondents to Outpatient Commitment proceedings and meet the criteria for Outpatient Commitment. Vaya accepts a copy of the Outpatient Commitment order for members who are served by Network outpatient treatment physicians and centers and ensures providers who are serving members on OPC have a copy of the OPC order.

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

Vaya requires network providers of services delivered pursuant to an Outpatient Commitment order to notify Vaya of the Outpatient Commitment order immediately upon receipt. Once Vaya is notified of the Outpatient Commitment order, Vaya Health shall refer the individual to case management services.

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

What is the process if a Network Provider is considering discharging a member on OPC?

If you determine that the individual no longer meets criteria to continue the OPC, the MD/licensed psychologist/FNP/PA must complete a Notice of Commitment Change Form. Once completed, you must send one copy to the Clerk of Court in the county the court order dictates (which is the county of supervision) and one to the assigned Vaya care manager, who will log the termination of commitment. If the individual was initially committed as a result of conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court's office for clarification.

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

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

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

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

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

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

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

What if these reasonable professional efforts are unsuccessful?

You must document the efforts made, including three attempts at face-to-face contact over a four-week period, in a letter to the Clerk of Court's office in the supervising county, complete a Notice of Commitment Change and send the form to the Clerk of Court, with a copy to the assigned Vaya care manager. Remember that if the member is initially committed as a result of conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and the member was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment.

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

What is the review process for continuation of OPC?

Prior to the expiration of the OPC, the Network Provider clinician must review the case with an MD/licensed psychologist/FNP/PA and determine if the member still meets the criteria for OPC and whether it needs to be extended. If the member has been compliant and no longer meets the criteria, the duration of the OPC will naturally

expire. If you determine that the member continues to meet the criteria for the OPC and a rehearing is needed, then the MD/licensed psychologist will need to complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment, Form 5-72-09, available at https://www.ncdhhs.gov/documents/mhddsas-legal-forms-hospitals. This form, along with a completed Request for Hearing Form, must be submitted to the Clerk of Court, with a copy to the assigned Vaya care manager.

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

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

What if the member moves to another Tailored Plan region?

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

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

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

What if the member wants to change providers?

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

Substance Abuse Commitment

Involuntary Substance Abuse (SA) commitments generally take a great deal of coordination between community-based outpatient providers (SAIOP, SACOT, etc.) and potential inpatient treating facilities (state Alcohol and Drug Abuse Treatment Facilities, local FBC or detoxification facilities). An SA commitment order is a hybrid of inpatient and outpatient care. SA commitments are for 180 days, of which 45 consecutive days can be inpatient. If longer inpatient time is needed, a re-hearing must be held.

At this hearing, 90 days can be ordered inpatient. Members under SA commitment who do not comply with treatment can be picked up by law enforcement, evaluated in the community and then admitted to a 24-hour treatment facility if

inpatient criteria are met (without a new petition). In such cases, the Network Provider must complete Request for Transportation Order and Order (Committed Substance Abuser Fails to Comply with Treatment or is Discharged from 24-Hour Facility AOC-SP-223), available at: http://www.nccourts.org/Forms/Documents/854.pdf, and submit it to the Clerk of Court's office, with a copy to the assigned Vaya care manager.

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

Crisis Prevention/Response

THE CRISIS CONTINUUM

There is a strong continuum of services available to help support and stabilize members in crisis. Crisis services include Mobile Crisis Management (MCM) team, Facility Based Crisis (FBC), non-hospital detoxification, walk-in crisis, NC START or use of a hospital ED for reasons related to psychiatric illness or substance use. As a Network Provider, you must be aware of the resources available, how to access crisis response services, implement them to fit the nature of the member's crisis and understand your role and responsibilities within the crisis continuum. Vaya contracts with multiple MCM teams to provide coverage for all 31 counties in our region. There are walk-in centers in each county, operated by Vaya's contracted Comprehensive Care providers, where members can go to receive same-day assessment and treatment. There are also FBC centers serving the Vaya region. As discussed below, basic benefit providers may utilize MCM for face-to-face assessment and intervention if the provider's phone response does not reduce the crisis.

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

COMPREHENSIVE CRISIS PLAN DEVELOPMENT

All MH/IDD/SUD Network Providers are required to develop Comprehensive Crisis Plans (CCPs) for members they serve as part of the person-centered planning process. In addition, all Network Providers must follow the state's Comprehensive Crisis Intervention and Prevention Plan guidance: http://crisissolutionsnc.org/wp-content/uploads/2014/01/crisis-crisisplnmemo8-20-14.pdf. The CCP must be created with input and participation from the member and natural supports and include provider and support person contact information, prevention, and early intervention strategies for the member to utilize and must include member-identified strategies to be

utilized by professionals if the member needs to access crisis services. It is designed to be one section of a person-centered plan or care plan that can also be easily extracted as a stand-alone document for ease of distribution.

Who is required to have a Comprehensive Crisis Plan?

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

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

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

How and when is the CCP updated and shared?

Individuals receiving services must be provided with a copy of the plan and all pertinent crisis contact/after-hours numbers to utilize in an emergency. CCPs are “living documents” and must be reviewed and updated as needed. Plans are required to be updated annually and whenever a member’s medications or natural supports change or other significant change occurs that impacts crisis planning. CCPs should be reviewed after every crisis event (such as utilizing MCM, an ED stay and/or a psychiatric hospitalization) and updated as needed. Network Providers must upload all completed CCPs to the member’s MCIS profile labeled with member’s initials,_CCP_Date (YYMMDD), for example: JD_CCP_20151001, and identified as document type “Crisis Plan.” This enables the plan to be easily retrieved and shared in a crisis. Where permitted under applicable privacy laws, Vaya may share a member’s CCP with an ED or a MCM provider to help alleviate or respond to a crisis. For this reason, it is critical that CCPs be uploaded as soon as possible following completion or any updates to the plan.

Members enrolled in Tailored Care Management also have crisis plans with their care managers. See Section 4 for more information on the relationship between the Care Management crisis plan and behavioral health provider’s crisis plans.

Transition, Discharge and Provider Closures

Network Providers are required to refer members for specialty care or to other contracted providers in response to a member request, change in member’s level of care or change in the Network Provider’s status within the Vaya Network. You must ensure continuity of care for members in such circumstances, limit potential disruption in services and cooperate with all transition and discharge activities, including, but not limited to, complying with all referral and documentation requirements.

MEMBER REQUEST

If a member requests to change providers, you must assist the individual in transitioning to the new provider of his or her choice. This includes providing them with a list of alternate providers, making the new appointment or working with Vaya’s Member Services Department to obtain an appointment with the new provider and ensuring

all health records necessary to ensure continuity of care are shared with the new provider as soon as possible. It is not acceptable to discourage a member from selecting a new provider or practitioner or to charge a fee for the transfer of medical records.

CHANGE IN LEVEL OF CARE

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

DISCHARGE FROM LICENSED FACILITIES

In accordance with N.C.G.S. § 122C-63, providers must notify the member and Vaya if you intend to close an I/DD residential facility or to discharge a member from an I/DD residential facility ***at least 60 days prior*** to the closing or discharge. Members residing in other non-I/DD 24-hour licensed facilities such as mental health group homes or adult care homes must be provided with ***at least 30 days' notice*** prior to closure or discharge. These timeframes are necessary to protect continuity of care and give the member time to find a new place to live. Vaya strictly enforces these timeframes and will report any violation 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 communicated in writing to provider.info@vayahealth.com or your assigned Provider Network Manager:

- Whether the entire organization is closing, or only a part of it, and which part(s) or site(s), as well as whether you are closing all operations within the state of North Carolina
- The date of site closure, end of operations or effective date of specific service elimination

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

- A list of the names and dates of birth of affected members and the services they are currently receiving (affected Members include those seen by your agency within 60 days of notification of the transition)
- Which notifications you made and when (e.g., to government agencies, to members, to other providers) and the method of such notifications
- A list of members currently receiving medication management services, with prescription due dates. We strongly encourage you to issue 90-day prescriptions to individuals prior to closure or service termination, when medically appropriate.
- Whether you made any arrangements for referral of Vaya members to other providers
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals

- A list of credentialed practitioners who will no longer be employed by you, if applicable
- A list of employees who will continue to have access to the MCIS during the closing process, and the date such access should be terminated

In voluntary closure situations, you must send a written notification to members/LRPs advising of the closure, including effective date, must immediately begin to work on referrals of members to other service providers. Vaya will also send a written notice to affected members and/or LRP. If you did not provide any services to Vaya members and had no active service authorizations within the preceding 60 days, no notification to members is necessary.

INVOLUNTARY PROVIDER CLOSURE

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

- A list of the names and dates of birth of affected members and the services they are currently receiving
- A list of members currently receiving medication management services, with prescription due dates. We strongly encourage you to issue 90-day prescriptions to individuals prior to closure or service termination, when medically appropriate.
- Whether you made any arrangements for referral of Vaya members to other providers
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals
- A list of credentialed practitioners who will no longer be employed by you, if applicable
- A list of employees who will continue to have access to the MCIS during the closing process, and the date such access should be terminated

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

Members receiving active treatment for acute or chronic behavioral health conditions may continue to receive services with the Provider through the period of active treatment, or for 90 calendar days after the closure/change in services, whichever is less. The Provider must notify UM of the members undergoing active treatment, and the transition plan for such members. For continuing services to be authorized by UM, the Provider must agree to continue treatment for an appropriate period of time based on the transition plan goals, share ongoing information about treatment plan progress with UM, continue to follow UM policies and procedures, and charge only the required copayment, if applicable.

CLOSURE RESPONSIBILITIES

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

- If requested by the receiving provider, you must actively participate in treatment team, transition and/or discharge planning meetings until such time as all members in your care are transitioned or discharged.
- You may be subject to a final post-payment review to occur within 60 days of contract non-renewal/termination/withdrawal.
- Regardless of the reason for closure, you are required to retain, or arrange for the retention of, all original member service records. You must submit a written plan for maintenance and storage of all records of services provided to Vaya Health Plan members at least 30 days prior to the end date of your contract, as well as a master records list that includes the member's name, service record number, date of birth, last date of service, Medicaid number and county of Medicaid origin, if applicable.
- Records must be stored in an environment that ensures the continued preservation and safeguarding of records to protect their privacy, security and confidentiality for the duration of the statutorily required record retention period.
- The written plan must include a copy of your record storage log and documentation that outlines where the records are stored, the designated custodian of records and contact information for the custodian of records.
- Vaya has the sole discretion to approve or disapprove any such plan. If the plan is not approved, we may require you to arrange for electronic or paper copies of such records to be transferred to our possession within 15 days of the request. 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 assist with Vaya taking possession of the records. Records must be transferred in an organized and searchable format.
- Paper record storage logs must include the:
    - Name of provider
    - Date of storage
    - Series/box number (box 1 of 3)
    - Start date and the end date of the contents in the box
    - Record type or the name of the individual. Record type refers to the classification of the particular information contained in the box. Please store records of the same type in the same box.
    - Record ID number or any other identifying number or information
    - Date of birth recorded for individual service records. In the case of personnel records, the employee's date of birth is to be recorded for quick reference.
    - Timeframe of the information stored in a particular box. For example, you would record an admission of 1/2/09 – 9/13/09 or an employment period of 2/12/09 – 12/13/09, or a specific timeframe (e.g., October 2002 Cost Reporting, etc.).
- All claims for services must be submitted within 60 days of contract non-renewal, termination or withdrawal. Claims will be adjudicated on the published checkwrite schedule, unless Vaya suspends your final payment to ensure compliance with all transfer and closure requirements outlined in this section:
    - If you fail to comply with member records transfer or other referral or transition obligations, we reserve the right to withhold any remaining payments that may be due until such time as the Vaya Legal and Compliance Department approves release of funds.
    - If you fail to submit an acceptable records management plan, we reserve the right to withhold any remaining payments that may be due until such time as the Vaya Legal and Compliance Department approves release of funds.
    - If you owe any outstanding overpayments or other amounts to Vaya, we will apply any remaining payments that may be due against your accounts receivable before releasing any funds remaining.

6

SECTION 6 |
Network Requirements

Non-discrimination Statement

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

Discrimination in general means treating a person unfairly because of who they are or because they possess certain characteristics. Per Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C §2000d et seq., "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Discrimination that occurs because of any characteristic protected by federal, state, or local law is unlawful and in direct violation of Vaya policy.

Vaya does not discriminate on the basis of any protected classification or characteristic, including, but not limited to, race, color, creed, religion, ancestry, sex, gender identity, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information, health status/need for health services, or National Guard, Veterans', marital, parental, or other protected status, in compliance with laws that prohibit discrimination. Vaya also does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment or based on practitioner or facility license or certification type.

Vaya provides the following to support effective communication with us:

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

NON-DISCRIMINATION LAWS

Vaya complies with all applicable federal and North Carolina 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 identify 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 which regularly employ fifteen (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.

Accessibility and Cultural Competence

An important prerequisite to network participation is the development of a Cultural Competency Plan (CCP) that includes education regarding accessibility and support services. Vaya developed a CCP and requires Network Providers to develop and implement a CCP that is respectful and supportive of the cultural and diverse needs of members, families, stakeholders, communities, and other agencies. Network Providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Cultural competency is a guiding principle that must be incorporated into your mission and values and reflected in your decisions, policies, clinical protocols and established benchmarks and outcome measures. We require Network Providers to practice person-centered thinking in every aspect of service delivery to achieve cultural competence.

Providers are successful in achieving a culturally competent organization when the skills and abilities needed for cultural competence become a priority at every level of the organization, including leadership.

Providers must develop and implement strategies for addressing the special needs of the Medicaid population and to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and/or illiteracy, or who may be non-English speaking. Training shall include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay Video Conference Captioning, Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

Providers must provide members with verbal and written information concerning resources for transportation offered by the Medicaid Program and available in the county as well as referrals to available community services and supports. Providers must also ensure that interpreter services are made available by telephone or in-person at no charge to the member or to Vaya. If at any time Vaya discovers that a Member/Recipient or potential Member/Recipient has been charged for translation or interpreter services by a provider, Vaya's Vice President of Regulatory Affairs will notify the Department in writing within five business days. A provider may submit an enhanced rate request if the interpretation or other special needs of the member imposes a cost burden on the provider, but Vaya does not guarantee approval of any rate enhancement request.

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

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

INDIVIDUALLY

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

ORGANIZATIONALLY

- Identify and adopt appropriate cultural diagnostic tools and train staff on their utilization.
- Advertise position openings in markets where minorities are exposed to the ads.

- Evaluate outreach and marketing strategies to ensure targeted communities and populations are reached.
- Practice inclusiveness.
- Acknowledge the interactive dynamics of cultural differences.
- Continuously expand cultural knowledge and resources about populations served.
- Collaborate with the community regarding service provision and delivery.
- Commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
- Earnestly participate in initiatives to achieve cultural competence.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner.
- Recognize and work to reduce potential barriers to physical and behavioral health treatment:
    - Stigma associated with receiving services
    - Distrust of the system
    - Perceived lack of confidentiality
    - Services not located in the community where they are needed
    - Lack of transportation
    - Poverty
    - Language
    - Fear, of discrimination or otherwise
    - Family or community shame
    - Lack of providers with a culturally appropriate or diverse staffing base

Network Providers are required to complete a Cultural Competence Self-Assessment Tool annually. Areas to be assessed include:

- Staff composition
- Physical environment
- Written materials
- Website
- Phone system
- Policies and procedures
- Training program
- Communication of the program

On-call Coverage

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

PROVIDERS OF BASIC BENEFIT SERVICES

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 members they serve.

- Basic benefit providers must offer an answering service or voicemail with the provider's after-hours contact number. The message must not direct members to 911 or the ED unless their emergency is life-threatening. All members must be provided with the mobile/pager/answering service number of the clinician who is on call. If the provider is using an answering service, the provider must return the call to the member within 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 crisis. Members should have copies of the crisis plan and pertinent contact/crisis after-hours numbers for providers.
- Basic benefit providers responding to members in crisis must have 24/7 access to crisis plans and other information in the member's treatment record to guide crisis intervention.
- Basic benefit providers must be able to respond telephonically but may access MCM services for the member if telephone contact cannot mitigate the crisis.

BEHAVIORAL HEALTH CLINICAL HOME AND PROVIDERS OF ENHANCED SERVICES

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

- All the above stipulations listed for basic benefit apply to BHCH and enhanced services providers.
- In addition, these providers must be available 24/7 to respond to members receiving services from them both telephonically and face-to-face for crisis response, as needed.
- BHCH and enhanced service providers (IIH, MST, CST, ACTT, SAIOP, SACOT) must respond with a face-to-face contact if telephone contact is not successful in mitigating the crisis.
- First responders are responsible for obtaining involuntary commitment (IVC) petitions, if necessary. See Section 5 of this Manual for more information about the IVC process.

WHO AND WHAT ARE CLINICAL HOME PROVIDERS?

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

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

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

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

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

RELATIONSHIP BETWEEN FIRST RESPONDERS AND MOBILE CRISIS

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

Mobile Crisis Management (MCM) teams are required to promote effective linkages between all Intellectual Developmental Disability crisis service providers, by establishing and maintaining formal, written affiliation agreements. The agreements must be developed collaboratively between MCM providers and all Intellectual Developmental Disability crisis services providers in the region and must outline the roles and responsibilities of both parties.

INNOVATIONS WAIVER PROVIDERS OF DIRECT CARE SERVICES

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

- Community Living and Support
- In-Home Skill Building
- Personal Care
- Residential Support services

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 he or she receive services.
- The minimum standard is that the provider must first assess by phone to determine if face-to-face support is needed. The assessment will include determining if crisis response services are necessary. The provider is responsible for knowing how to access crisis response services and implement them to fit the nature of the crisis.
- MCM is not considered a primary crisis responder for individuals receiving the above-listed services unless, after an initial assessment, the responsible provider feels that MCM is needed to assist with ED diversion.
- Members have the right to select another crisis response services provider from within the Closed Network.
- Care Plan crisis plans must be inclusive of mental health or medical health supports and their contact information. All providers listed on a crisis plan must know and understand their role in a crisis for that participant, including MCM. Crises can occur in the form of mental health, behavioral or medical needs.

DIRECT CARE PROVIDERS OF STATE-FUNDED I/DD SERVICES

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

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

FREQUENTLY ASKED QUESTIONS

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

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

What if the case is closed or transferred? Or the member has not been seen in a long time?

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

When should an MCM team be called to handle a member who is in crisis?

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

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

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

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

Yes. Vaya Network Providers must upload CCPs and person-centered plans into the MCIS to support continuity of care, both at the time of first signature and whenever revisions are made. Crisis plans must be updated when the person-centered plan is updated or when there is any significant change in functioning (e.g., a crisis event or hospitalization). As stated earlier, updated plans should be uploaded to the MCIS. As with any revision to the person-centered plan, a signature is required.

CRISIS PREVENTION AND EDUCATION EFFORTS

As a MH/IDD/SU or Tailored Care Management Network Provider, you must participate in crisis prevention and education efforts to minimize crises experienced by members you serve, reduce stigma, and educate the community about services you offer. These efforts should include but are not limited to: crisis plan development and implementation; required after-hours response and first responder duties; local Crisis/Emergency Department Initiative (CEDI) committee activities; development of prevention, education, and outreach programs; and distribution of educational material and brochures on mental illness, I/DD, and substance use disorders. For requirements related to crisis plans for Members receiving Tailored Care Management please refer to Section 4, Tailored Care Management, of this manual.

Credentialing and Re-credentialing

Identification of Service Needs

Vaya is committed to ensuring the fiscal stability of its contracted Network Providers and will only consider applications from ***new*** applicants for behavioral health and I/DD services delivered through the Closed Network if service capacity is not met, i.e., there is a demonstrated community or member service need. If Vaya identifies and approves a specific service need as the result of the Network Access Plan for Medicaid or the Network Access Plan for State-funded Services analyses or based on an internal review, Vaya may seek to add providers through a

variety of means, including, but not limited to, direct provider contact, solicitation of applications via the weekly bulletin or website posting or development of a procurement process for selection of an appropriate provider. Providers should check the Vaya website regularly for this information.

The first step is for the interested applicant to complete and submit a Provider Nomination Form, available on our website. If the nomination is approved, the provider must complete or update all necessary information in NCTracks, where all provider information is gathered and processed for credentialing and enrollment as a Medicaid or state-funded services provider.

SELECTION (ENROLLMENT) CRITERIA FOR THE CLOSED NETWORK

For enrollment as a new provider in the Closed BH I/DD Vaya Network to be approved, the applicant must meet all the following criteria as determined by Vaya, as applicable to the provider type. We specifically reserve the right to conduct an on-site review at any time to confirm provider compliance with these criteria and further reserve the right to reject any applicant or provider who does not meet these criteria as determined by Vaya:

1. There must be a need for the service the applicant is seeking to provide.
2. The applicant must meet all NCDHHS credentialing and/or re-credentialing requirements.
3. The applicant must be in good standing as defined in this manual.
4. The applicant must provide truthful and accurate information during the selection process, including in the enrollment, the NCDHHS-identified Credentials Verification Organization (CVO) credentialing and/or re-credentialing application and process.
5. The applicant must adhere to evidence-based or best practices where applicable and provide culturally competent services.
6. The applicant must demonstrate efforts to implement a customer service system that ensures good communication with members and families.
7. The applicant must have a “no-reject” policy for referrals.
8. The applicant must have a robust Compliance Plan that meets the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
9. The applicant must have a Quality Management Plan with evidence of implementation of strategies and goals.
10. The applicant must have adequate clinical leadership according to the disability and services being provided with a sufficient supervision structure.
11. With limited exceptions, all applicants must have a HIPAA-compliant Electronic Health Record (EHR) system that supports management of authorizations and billing functions. EHRs must be capable of sending HL7 messages (versions 2 or higher) to communicate with the N.C. Health Information Exchange (HIE), called 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 necessary to meet all clinical, quality improvement, billing and confidentiality standards required for providers of publicly funded healthcare services, including, but not limited to, infrastructure necessary to monitor all financial information of the company, such as debt-to-income ratio.

Network Provider Enrollment and Change Requests

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

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

Existing Network Providers of Innovations Waiver services seeking to add an additional Innovations Waiver service to their contract to serve a specific participant must be in good standing. The first step is for the provider to complete and submit the Provider Nomination Form. Determinations on such requests are based, in part, on information about whether the additional Waiver service is necessary to meet a specific need. If the request is for a residential service that requires additional credentialing, the provider must complete the credentialing process through the CVO. DHB guidelines require that all new applicants seeking to provide Innovations Waiver services must be nationally accredited in I/DD service provision and meet all Home and Community Based Services (HCBS) requirements.

RETENTION (RENEWAL) CRITERIA

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

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

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

  - Meeting all medical necessity and documentation requirements as set forth in Medicaid Clinical Coverage Policies, Non-Medicaid Service Definitions and/or the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2
  - Cooperation and participation with all Vaya network integrity activities (including, but not limited to, audits, investigations, and post-payment reviews), as well as Vaya process for utilization review/management, quality management, incident reporting and member appeals and grievances
- The Network Provider has not billed for services in the 60 days prior to Vaya's review of the contract renewal unless it concerns an out-of-network provider, out-of-area provider, or provider of specialty services that are delivered infrequently.
- The Network Provider is not in good standing as defined in this Manual.
- Vaya, DHB or CMS determines that the Network Provider falsified information provided on documentation submitted for re-credentialing, screening or enrollment in the Vaya Closed Network or NC Medicaid.
- Vaya issued three or more Plans of Correction against the Network Provider for the same or similar out-of-compliance findings, for example, three findings related to lack of training (even if it referred to different trainings), within a six-month period.
- Vaya identified quality-of-care concerns, Level II or III incidents or other serious grievances about the Network Provider that were not satisfactorily resolved in required timelines.
- The Network Provider has a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Vaya.
- The Network Provider did not respond (or did not timely respond) to requests for data or other information necessary for Vaya to respond to requests from the state or CMS.
- The Network Provider fails to maintain and provide proof of insurance as required under the terms and conditions of the contract.
- The Network Provider fails to attain an 85 percent or higher Routine Post Payment Review (RPPR) score.
- The Network Provider routinely fails to satisfactorily complete and upload Service Authorization Requests (SARs) that meet Vaya UM requirements (i.e., a high percentage of administrative denials proportional to the numbers of members served; generally, anything higher than 10 percent is unacceptable).
- The Network Provider routinely fails to submit requests for SARs for continuation of currently authorized services at least 14 days prior to end of existing authorization – at least 75 percent of SARs must meet this standard.
- The Network Provider failed to implement an adequate emergency response system that complies with the requirements of contracted services, including the implementation of measures to respond to emergencies on weekends and evenings for members served by the Network Provider.
- The Network Provider routinely fails to meet DMH/DD/SAS access standards and appointment wait times or fails to comply with the no-reject policy for members referred by Vaya.
- The Network Provider did not meet or is unable to meet all re-credentialing requirements, including a failure to maintain any required facility or professional license.
- The Network Provider failed to cooperate and comply with discharge and transfer requirements to ensure a smooth transfer for any member that desires to change providers or because the Network Provider cannot meet his or her special needs.

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

- Efforts to satisfactorily implement an acceptable Cultural Competency Plan, including efforts to provide culturally competent services and ensure the cultural sensitivity of staff members
- Efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes
- Member service and health literacy efforts to implement a system that ensures good communication with members and families
- Evidence of cooperation with, and level of participation in, member and provider satisfaction surveys
- Implementation of a robust Corporate Compliance Plan and Quality Management Plan with evidence of strategies and goals being implemented by the Network Provider
- Evidence of adequate clinical leadership according to the disability and services being provided by the Network Provider with a sufficient supervision structure
- Efforts to implement a HIPAA-compliant Electronic Health Record (EHR) system that supports management of authorizations and billing functions. EHRs must be capable of sending HL7 messages (versions 2 or higher) to N.C. Health Information Exchange (HIE), called NC HealthConnex. Vaya prefers Network Providers who demonstrate compliance with the Federal Meaningful Use Standards and who can comply with clinical reporting requests.
- Demonstrated financial stability defined as having: (1) a minimum of one month's working capital or line of credit equal to the Network Provider's monthly gross income; and (2) no tax liens
- Demonstrated operations and information technology infrastructure in place necessary to meet all clinical, quality improvement, billing and confidentiality standards required for providers of publicly funded healthcare services, including, but not limited to, infrastructure necessary to monitor all financial information of the company, such as debt to income ratio

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

GOOD STANDING

All applicants and providers for the Closed Behavioral Health I/DD Network must be in good standing to be considered for initial enrollment or contract renewal. Good standing will be verified as part of the contract renewal processes as described earlier in this section of the Manual. **We consider a provider to be in good standing if all the following criteria are met:**

- The individual or entity and any owners, directors and managing employees are not excluded from participation in any federal health care program.
- The individual or entity and any owners, directors and managing employees have no relevant criminal history.
- The individual or entity and any owners, directors and managing employees did not previously own, operate, or manage any provider entity that had its participation in any state's Medicaid program, the N.C. Health Choice program, the Medicare program, or another Medicaid managed care program involuntarily terminated for any reason.
- The individual or entity and any owners, directors and managing employees did not previously own, operate, or manage any provider entity that owes an outstanding overpayment to U.S. HHS, NCDHHS, Vaya or another LME/MCO.
- There are no current NC Health Choice, Medicare or Medicaid fines or sanction(s) in effect against the individual or entity by CMS or its contractors, or any state Medicaid agency, including, but not limited to,

contract termination or suspension, referral suspension, payment suspension, moratorium, placement on prepayment review or similar actions.

- The individual or entity has an acceptable professional liability history, defined as no history of liability claims for the last five years. An unacceptable liability history is defined as: within the five-year period immediately preceding the date of application, one or more legal actions resulted in: (1) at least one judgment; (2) one settlement in an amount of $50,000 or more; or (3) two or more settlements in an aggregate amount of $50,000 or more.
- The individual or entity does not owe any outstanding payments, fees, or documentation to any of the federal or state oversight authorities listed below, including, but not limited to, outstanding tax or payroll liabilities:
    - U.S. Department of Health and Human Services (HHS) or any of its divisions
    - NCDHHS or any of its divisions
    - N.C. Secretary of State (if organized as a corporation, partnership, or limited liability company)
    - U.S. Internal Revenue Service (IRS)
- No negative or questionable findings are identified for the individual or entity in any of the following databases/oversight authorities:
    - U.S. HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
    - U.S. System for Award Management (SAM) consolidated excluded parties list
    - NCDHHS Program Integrity Exclusion List
    - N.C. Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR)
    - NCTracks and/or National Plan & Provider Enumeration System (NPPES)
    - National Practitioner Data Bank (NPBD/HPDB)
    - National Technical Information Service for DEA certificates
    - Social Security Death Master File
    - DHB Program Integrity Database/ State Exclusion List
    - National Accrediting Boards (e.g., CARF, Joint Commission on Accreditation of Hospitals)
    - Boards of Licensure or Certification for the applicable Scope of Practice
- The individual or entity is not currently subject to any of the following sanctions or administrative actions issued by Vaya, state or local regulatory agencies or has not been subject to any such sanctions or administrative actions within the 12 months prior to the application or 36 months for a renewal decision:
    - Vaya or other LME/MCO: Contract Termination or Suspension, Suspension of Referrals, Unresolved Plan of Correction (POC), Outstanding Overpayment, Prepayment Review, Payment Suspension
    - DHB: Contract Termination or Suspension, Payment Suspension Prepayment Review, Outstanding Final Overpayment
    - DMH/DD/SAS: Revocation of Authority to Receive Public Funds, Unresolved POC
    - DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active Summary Suspension, Active Notice of Revocation or Revocation in Effect
    - N.C. Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, Revenue Suspension

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

Vaya considers an action against a provider to be final upon notification to the provider, unless the provider timely requested a reconsideration review, in which case Vaya considers the action final upon issuance of a decision by a reconsideration panel. Vaya is not required to enroll an applicant in the Vaya Closed Network or renew a Network Contract if the individual or entity has an LME/MCO sanction pending in any administrative or judicial form, including but not limited to OAH.

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

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

CENTRALIZED PROVIDER ENROLLMENT AND CREDENTIALING

Under the Tailored Plan, NCDHHS is partnering with a designated CVO to implement a Centralized Credentialing and Re-credentialing Process with the following features:

- The Department, or Department-designated vendor, collects information and verifies credentials through a centralized credentialing process for all providers currently enrolled or seeking to enroll in NC Medicaid.
- The Department applies the credentialing policies to any providers who furnish, order, prescribe, refer, or certify eligibility for Medicaid, including all providers that must be credentialed under credentialing standards established by a nationally recognized accrediting body per 42 C.F.R. § 438.602(b).
- The process and information requirements meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization.
- Providers use a single, electronic application to submit information to be verified and screened to become a Medicaid-enrolled provider, with the application serving for enrollment as a NC Medicaid Direct provider and a Medicaid Managed Care provider.
- Providers are re-verified and re-credentialed every five years, except as otherwise specifically permitted by the Department in the Contract.

Vaya accepts provider credentialing and verified information from NCDHHS. Vaya makes contracting determinations based solely upon the credentialing information and Objective Quality Standards provided by DHHS. Vaya also uses its Provider Credentialing and Re-credentialing Policy to decide whether to contract with a provider enrolled to provide Medicaid or State-funded Services.

PROHIBITED AFFILIATIONS

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

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

A "relationship" is described as follows:

1. A director, officer, or partner of Vaya;
2. A person with beneficial ownership of five percent (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 which are significant and material to Vaya's obligations under its contract with the State.

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

CREDENTIALING VERIFICATION REVIEW

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

- State Exclusion List
- U.S. HHS, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE)
- The System of Award Management (SAM)
- The Social Security Administration Death Master File (SSADMF)
- To the extent applicable, National Plan and Provider Enumeration System (NPPES)
- 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 the Contract.

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

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

CONTRACTING

Vaya makes network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates. During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment Process, Vaya shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on a daily Provider Enrollment File. After the Provider Credentialing Transition Period, Vaya shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. Vaya must apply the Department's applicable Objective Quality Standards for participation as a State-funded Services enrolled provider to contracted providers every three (3) years unless otherwise notified by the Department.

All Network Providers must execute a written agreement with Vaya before any services can be authorized or reimbursed. These agreements must be in your official legal name, as identified on the N.C. Secretary of State database (for entities), or other legal form of identification (for independent practitioners). You may not assign any of your rights, interest, or title in your written agreement with Vaya without notifying Vaya in advance of the intent to transfer and without securing Vaya's written consent for the assignment of the written agreement. Failure to provide advance notice to and receive prior written consent by Vaya may result in termination of your contract.

A condition of Vaya's approval of an assignment of a Network Provider's written agreement to an assignee or acceptance of a successor owner for the Network Provider's assets or business operations is that the assignee or successor owner 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 back to dates of service prior to the assignment.

Provider contracts are on the state fiscal year cycle, from July 1 to June 30 of each year, with some providers offered an automatic renewal for one year. We use a unified contract template to ensure consistency across our network. The template does not include an attachment with a specific list of approved sites, services, and codes, eliminating the need for a contract amendment every time a change is made. Instead, providers must verify that accurate sites, services, and codes were correctly entered into the MCIS. Upon request, Vaya can generate a report that lists all sites, services, and codes associated with your contract. (Note: Providers must submit a request to Vaya to add new billing sites or services prior to the delivery of any new services or services rendered from new sites. Providing new services and/or rendering services from a new site that is NOT approved, credentialed, and incorporated in the MCIS will result in denied claims and/or adverse action.)

Please note that a cover sheet and Contact Maintenance Log is included at the front of your contract packet. Completing this log annually helps us improve the accuracy of contact information on file for Network Providers. **However, it is your responsibility to let us know if any of your information changes after the contract is executed.**

We utilize DocuSign®, a web-based platform that provides electronic signature technology and digital transaction management services, for facilitating electronic exchanges of Vaya contracts and signed documents. DocuSign® is legal and administratively efficient, and it and automatically provides you with a scanned copy of your executed contract following execution. It lowers administrative costs, reduces contracting process timeframes, improves the tracking of executed contracts, and helps ensure contracts are executed prior to their effective date.

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

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

OUT-OF-NETWORK AGREEMENTS

In situations where Vaya determines that our Network cannot meet the need for geographically accessible, appropriate, and/or timely services for a specific member, we may identify a selected out-of-network provider to meet the need. The first step in this process is to complete the Out-of-Network (OON) Agreement Request via DocuSign®, which is found on the provider enrollment page of Vaya's website at https://providers.vayahealth.com. If the request is approved, and all necessary information is submitted, Vaya will review and/or verify the following limited credentials necessary for successful claims adjudication and to ensure the health, safety, and welfare of members, as applicable to the provider type:

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

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

Access to Care

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

NO WRONG DOOR

Vaya follows a "No Wrong Door" approach to eligibility, enrollment, and access to care. This means that members can access services through our Member and Recipient Service Line or Behavioral Health Crisis Line, or by contacting a Network Provider – there is no wrong door to access treatment. All Network Providers are required to complete eligibility determinations and request enrollment of an eligible individual into a Vaya Health Plan. Vaya's walk-in centers offer same-day access for triage and/or assessment at offices located in each of the counties in our region.

Network Providers may conduct screening, triage, and referral following the process and criteria outlined below or may link individuals requesting services to Vaya's Member and Recipient Service Line at 1-800-849-6127. **In either case, all behavioral health and I/DD Network Providers are required to meet the applicable DMH/DD/SAS access to care timeframe based on a classification of the request as emergent, urgent, or routine.**

ELIGIBILITY

Individuals whose services are paid for in whole or in part by Vaya must meet eligibility criteria for a Vaya Health Plan. If you have any questions about whether someone is eligible for a Vaya Health Plan, please contact the Enrollment and Eligibility (E&E) Team at 828-225-2785, ext. 2355, or at EandE@vayahealth.com.

1115 MEDICAID WAIVER HEALTH PLAN

Individuals who receive a qualifying category of Medicaid from any of the 31 counties in our coverage area automatically qualify for Medicaid services. In general, to be eligible for Medicaid coverage, the individual must:

- Be a U.S. citizen or provide proof of eligible immigration status; AND
- Be a resident of North Carolina and provide proof of residency; AND
- Have a Social Security Number or applied for one; AND
- Meet Category of Aid eligibility criteria as determined by the county Department of Social Services (DSS) office where the individual resides.
- NOTE: Individuals currently receiving Supplemental Security Income (SSI) benefits, Special Assistance to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled are automatically eligible for Medicaid and do not need to apply at DSS.

* Some Medicaid Categories of Aid are not covered under the Vaya Health Plan and remain under DHB. Qualifying Categories of Aid are listed below:

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

- Medicaid beneficiaries admitted to Intermediate Care Facilities for individuals with I/DD

BH I/DD TAILORED PLAN ELIGIBILITY CRITERIA

- Enrolled in the Innovations or TBI Waivers, or on the waiting lists
- Enrolled in the Transition to Community Living Initiative (TCLI)
- Have used a Medicaid service that will only be available through a BH I/DD Tailored Plan
- Have used a behavioral health, I/DD, or TBI service funded with state, local, federal, or other non-Medicaid funds
- Children with complex needs, as defined in the 2016 settlement agreement
- Have a qualifying I/DD diagnosis code
- Have a qualifying SMI, SED, or SUD diagnosis code, and used a Medicaid-covered enhanced behavioral health service during the lookback period
- Have had an admission to a state psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episodes in a State-owned facility
- Have had two or more visits to the emergency department for a psychiatric problem; two or more psychiatric hospitalizations or readmissions; or two or more episodes using behavioral health crisis services within 18 months

Medicaid Direct Plan Eligibility Criteria

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

1915(c) INNOVATIONS WAIVER HEALTH PLAN

An individual must meet all the following eligibility criteria and be enrolled in the Innovations Waiver to receive these services:

- The individual is eligible for Medicaid coverage, based on assets and income of the applicant (not including family resources) whether he/she is a child or an adult.
- The individual's residence, for purposes of Medicaid eligibility, is within one of the counties in Vaya's catchment-area.
- The individual is assigned a Waiver "slot." Note that Innovations Waiver slots are allocated by DHB to each LME/MCO. Waiver slot enrollment is approved on a first-come, first-serve basis. Vaya maintains a list of

individuals wishing to be considered for participation in the Innovations Waiver, known as the Registry of Unmet Needs.

- The individual meets the requirements for ICF-IID level of care as approved by the Vaya UM Department.
- The individual lives in an ICF-IID facility or is at high risk for placement in an ICF-IID facility. High risk for ICF-IID institutional placement is defined as a reasonable indication that the individual may need such services soon (one month or less) in the absence of Home and Community-Based Services.
- The individual's health, safety and wellbeing can be maintained in the community through a combination of Waiver and natural supports.
- The individual qualifies for Innovations Waiver services, i.e., the services are medically necessary and appropriate for the individual. The individual must use at least one Waiver service per month for eligibility to be maintained.
- The individual and his/her family or guardian desires participation in the Innovations Waiver program rather than institutional services.
- N.C. Innovations Waiver participants must live in a private residence, with family, or in a living arrangement with six or fewer persons unrelated to the owner of the facility.

TBI WAIVER

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

Individuals whose services are paid for in whole or in part by Vaya must meet eligibility criteria for a Vaya Health Plan. If you have any questions about whether someone is eligible for a Vaya Health Plan, please contact the Enrollment and Eligibility (E&E) Team at 828-225-2785, ext. 2355, or at EandE@vayahealth.com.

NON-MEDICAID HEALTH PLAN

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

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

ENROLLMENT

Individuals whose services are paid for in whole or in part by Vaya must be enrolled in a Vaya Health Plan. If you have any questions about an individual's enrollment status, please call the Vaya Enrollment & Eligibility (E&E) Team at 828-225-2785, ext. 2355. You can also email the E&E Team at EandE@vayahealth.com or calling 828-225-2785 ext. 2355 Monday-Friday between 8:30 a.m. and -5 p.m. It is your responsibility to make a complete and thorough investigation of an individual's ability to pay prior to requesting to enroll that person into a Vaya Health Plan. This means that you must check for the following:

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

After eligibility is established, Network Providers are required to enroll individuals for services without prior screening, triage, or referral by Vaya. If the individual has Medicaid or was previously enrolled in a Vaya Health Plan, he or she may be eligible for publicly funded services through Vaya. If the individual was previously enrolled in a Vaya Health Plan but claims for services were not submitted for more than 90 days, you must complete a new enrollment. If the individual is not yet enrolled, then you must obtain and submit all data necessary to do so.

Required data elements include Medicaid ID number, if applicable, date of birth and identification of any other third-party payor, including Medicare. It is your responsibility to ensure that enrollment data is accurate and up to date. If enrollment data is not accurate or complete prior to service provision, your ability to successfully submit authorization requests and claims may be impacted.

Member enrollment must be performed electronically through the Vaya system**. Enrollment can be verified by contacting the E&E Team at 828-225-2785 ext. 2355 Monday-Friday between 8:30 a.m. and 5 p.m.** Providers may also call the Provider Support Service Line **after hours and on weekends** at 1-866-990-9712 to verify eligibility. You must complete the eligibility determination and enrollment request prior to service provision, except for crisis services provided in a documented emergency. Claims submitted for services provided prior to date of enrollment will be denied.

MEMBER SERVICES DEPARTMENT

The Member Services Department operates a toll-free Member and Recipient Services Line at 1-800-962-9003 for telephonic screening, appointment referrals and general member and recipient questions. The line is operational from 7 a.m. to 6 p.m., Monday through Saturday. During times of heavy call volume, overflow calls may be automatically redirected to another Tailored Plan for backup. The Member Services Department also operates a toll-free, 24/7/365 Behavioral Health Crisis Line at 1-800-849-6127.

Member Services also provides the public and local communities with general information via the 1-800-962-9003 toll-free number. This toll-free number can also be used to report a compliment, complaint, or concern about

Vaya or any of our Network Providers. The Member Services Department is staffed by Member Services Representatives (MSRs) and Member Services Clinicians:

- MSRs are bachelor-level or non-licensed Qualified Professionals with at least two years of experience in the human services field. Their primary job responsibilities are to answer the telephone calls coming into the Member and Recipient Service Line, collect demographic information, verify insurance eligibility, and complete a brief intake screening to determine the type and level of service/s most appropriate for callers. MSRs can also provide information about community resources, provide information about inpatient facilities when appropriate, follow up to ensure members discharged from inpatient facilities are engaging in the next level of care, and follow up on all appointments made through Vaya to ensure members are attending scheduled appointments.
- Member Services Clinicians are master's-prepared licensed professionals who handle emergency and crisis intervention calls, as well as regular MSR duties. Member Services Clinicians follow all requests for emergency services until it is established that contact is made with a Mobile Crisis Management (MCM) provider, first responder or other provider. Member Services Clinicians are available to take over calls with members who are in distress.

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

- Crisis intervention, including referral to MCM
- Management and provision of referrals for urgent and emergent calls
- Referrals for Diagnostic or Comprehensive Clinical Assessments
- Information about community (non-treatment) resources
- Enrollment of an individual into a Vaya Health Plan
- Eligibility questions
- Recording and resolution of complaints or grievances
- General information about Vaya and publicly funded services available in our region

SCREENING, TRIAGE AND REFERRAL PROCESS

If the member contacts Vaya's Member Services Department

If a caller does not request a clinical assessment or treatment services, the MSR will offer suggestions for obtaining natural supports and/or community services. If a caller requests a clinical assessment or treatment services, the MSR will gather demographic information and determine whether risk indicators are present that necessitate involvement of a clinician.

If the call involves no risk indicators, the MSR offers a choice of available Network Providers and links the caller to the selected provider for an intake appointment. When risk indicators are identified, the MSR involves a clinician to determine the most clinically appropriate referral and clinical urgency with which the caller should be seen by the referred provider: Emergent, Urgent or Routine.

If the member contacts a Network Provider

If a caller does not request a clinical assessment or treatment services, you must offer suggestions for obtaining natural supports and/or community services. If a caller requests a clinical assessment or treatment services, you must gather demographic information and determine whether risk indicators are present that necessitate

involvement of an appropriately licensed practitioner. If the call involves no risk indicators, you must schedule an intake appointment. When risk indicators are identified, you must ensure involvement of an appropriately licensed practitioner to determine the most clinically appropriate referral and the clinical urgency with which the caller should be seen by the Network Provider: emergent, urgent, or routine.

Potential risk indicators include, but are not limited to, the following:

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

SCREENING, TRIAGE AND REFERRAL CRITERIA

Emergent Service Requests

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

- The member has a current significant risk related to safety or supervision, as evidenced by:
    - Risk of harm without supervision, such as walking into traffic or wandering
    - Current harm without supervision
    - Impaired reality testing, such as delusions or hallucinations
    - Dangerous disruptive or bizarre behavior
- The member presents current significant risk of harm to self or others, as evidenced by:
    - Verbalized or implied threats to physically harm self or others
    - Verbalized or implied plan to physically harm self or others
    - Active cutting or burning self
    - Current self-harm or of harm to others
- The member has severe incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health and/or I/DD issue(s), such as:
    - Actively psychotic with impaired self-care functions, as in unable to care for self on a daily basis regarding food, hygiene, toileting, etc.
    - Bizarre thought processes
    - Recent physical, cognitive, or behavioral incapacitation related to behavioral health and/or I/DD issue(s)

- The member indicates multiple withdrawal symptoms or reports a history of severe withdrawal and current/recent heavy use or recent referral for detoxification. Symptoms include tremors, paroxysmal sweats, anxiety, agitation, tactile disturbances (itching, bugs crawling, pins, burning sensations), auditory disturbances, visual disturbances (e.g., light sensitivity, seeing things not there), headache, disorientation regarding date and/or inability to do simple math (additions).

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

Urgent Service Requests

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

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

Urgent services may be provided through an outpatient clinic or office, through a walk-in service, or by a MCM Team.

Routine Service Requests

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

- The member has mild to no risk related to safety or supervision, as evidenced by ability to care for self on a daily basis.
- The member presents no risk of harm to self or others, as evidenced by denying any thoughts or plan of harm to self or others.

- The member has mild to moderate incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to behavioral health and/or I/DD issue(s). An example is member's mental health symptoms cause distress but are not currently incapacitating.
- The member shows no indicators of significant risk for substance use withdrawal symptoms as evidenced by:
    - Mild agitation, anxiety, or depression
    - Member reports minimal recent use or no substance use within the past several days
    - No history of significant withdrawal
    - Member demonstrates motivation for treatment by agreeing to attend 12-step support during the period prior to assessment

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

DMH/DD/SAS ACCESS TO CARE TIMEFRAMES

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

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

Failure to meet these timeframes may result in referral for investigation and administrative action or sanction, up to and including termination of your contract with Vaya. Network Providers should offer hours of operation that are not less than the hours of operation offered to commercial Members or comparable to Medicaid Fee-for-Service, if the provider services only NC Medicaid members. Providers are encouraged to offer after hours and weekend hours to address the needs of the member.

PRIMARY CARE PROVIDER ACCESS TO CARE STANDARDS

Wait time for appointment:

- Urgent (not life threatening but needs care within 24 hours)
    - Pediatrics – see within 48 hours
    - Adults – see within 48 hours
- Symptomatic non-urgent
    - Pediatrics – see within 30 calendar days
    - Adults – see within 30 calendar days
- Follow-up of urgent care
    - Pediatrics – see within seven days
    - Adults – see within seven calendar days

- Chronic Care follow-up
  - Pediatrics – see within 14 days
  - Adults – see within 14 calendar days
- Complete physical/health maintenance
  - Pediatrics – see within 60 calendar days
  - Adults – see within 60 calendar days
- Time in waiting room
  - Scheduled – after 30 minutes, Member must be given an update on waiting time with an option of waiting or rescheduling. Maximum wait time is 60 minutes.
  - Work-Ins/walk-Ins (called the day prior to coming) – after 45 minutes, Member must be given an update on waiting time with an option of waiting or rescheduling. Maximum wait time is 90 minutes.
- After hours coverage
  - Urgent – 20 minutes
  - Other – 60 minutes
- All in-network PCPs are required to have recorded telephone message instructing the Member to go to the ER for a life-threatening event or refer them to the physician on-call, to the answering service or nurse triage service.
- All in-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 in-network PCPs are required to post hours during which appropriate personnel is available to Members
  - Daytime – seven hours per day/five days per week
  - Nighttime – 24 hours/day coverage
  - Weekend – 24 hours/day coverage

REFERRALS AND APPOINTMENTS

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

If you wish to receive regular referrals for appointments from Member Services, you must create appointment slots in the MCIS. For more information on how to complete that process and what to expect from a referral, please email Member.Services@vayahealth.com.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

If a Medicaid beneficiary needs transportation for non-emergency health care services covered by Medicaid, Vaya can arrange and pay for transportation to and from appointments at a health care provider's office, a hospital, or another medical office. We can also arrange for member transportation to the pharmacy to pick up prescription medications. This service is called Non-Emergency Medical Transportation (NEMT), and it is free to all eligible Medicaid members.

Vaya will also pay for transportation for an attendant to go with the member to the appointment, if needed. If an adult is a parent or guardian of a child (age 18 or younger) who is a member of the Vaya Health Plan, we will also pay for that person to accompany them. To request non-emergency transportation services, members must call the Member and Recipient Service Line at 1-800-849-6127 up to two business days before the appointment. Vaya can also help members get transportation to and from an urgent appointment that they did not know about in advance.

The member must be able to arrive at the provider's location in time for the scheduled appointment, but not more than one hour before the appointment. The member must stay until their treatment or other service is finished, and the member will be picked up within an hour after your appointment ends. Non-emergency transportation includes personal vehicles, taxis, vans, mini-busses, mountain area transports and public transportation. Vaya will pay for the least expensive transportation method that meets the member's needs.

Vaya has contracted with a company called ModivCare to manage NEMT services for Vaya members. In the past, local DSS offices managed NEMT services. The amount, duration, and scope of available non-emergency transportation has not changed under Medicaid Managed Care. However, there are rules the member must follow, including limits on transportation, expected behavior and "no-shows". If we deny a member transportation services, the member has the right to appeal our decision.

Medicaid is required to provide transportation to medical appointments, or for pharmacy prescription pickups, for all eligible individuals who need and request assistance with transportation. Under Medicaid Transformation, the responsibility for providing NEMT services transitioned from county DSS agencies to Tailored Plan administrators for those beneficiaries enrolled in Medicaid Managed Care. Despite this change in NEMT responsibility, the amount, duration, and scope of NEMT services for Medicaid Managed Care does not change.

Individuals not eligible to receive NEMT services from the Tailored Plan include NC Medicaid Direct beneficiaries; members in a nursing home - the facility is responsible for providing transportation to their patients; or members transferring between facilities and/or hospitals.

For beneficiaries in NC Medicaid Direct, county DSS agencies will continue to arrange for NEMT services. Counties will continue to follow North Carolina NEMT policies, and providers will continue to bill NC Tracks for reimbursement.

For all Medicaid beneficiaries – NC Medicaid Managed Care and NC Medicaid Direct – transportation is available if the beneficiary receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider). Medicaid only pays for the least expensive means suitable to the beneficiary's needs and there is no fee for Medicaid beneficiaries to access NEMT.

For those not enrolled in Medicaid, county-provided public and human services transportation depends on available space, charges a fee, and is largely unavailable in the evening or on weekends.

As a Vaya Network Provider, you must assist the members you serve in accessing NEMT services, and this section of Vaya's Provider Operations Manual is designed to help you in that effort.

ModivCare Transportation Broker Services

Vaya has contracted with ModivCare as its transportation broker to administer and arrange NEMT services for its Medicaid Managed Care beneficiaries. As a Vaya Network Provider, ModivCare will help you facilitate access to NEMT services for the members you serve.

ModivCare offers a comprehensive network using transportation providers who are familiar with the Tailored Plan and are equipped with specific situational behavioral health training to handle Member needs during transportation. ModivCare evaluates prospective transportation providers, including a complete evaluation of appropriate licensing, adequate insurance coverage, civil and criminal records check, and background checks on personnel providing services. ModivCare continuously assesses its network coverage to determine areas where the addition of providers will enhance the trip timeliness and highlight cost-containment opportunities.

The ride request and scheduling process begins when a member, Complex Care Manager, or ModivCare's Medical Transportation Coordinator (MTC) determines that transportation services are needed for a member. Members seeking NEMT services can contact ModivCare directly and can also talk to a Vaya MRS Representative and will be warm transferred to ModivCare. Members may also contact their Complex Care Manager for scheduling assistance. ModivCare operates during the hours of 7:00 am to 7:00 pm Monday-Friday, maintains phone line operations Monday-Friday; and has an after-hours recording that provides the option to leave a message to be returned the next business day.

ModivCare verifies each member's Medicaid eligibility against a daily eligibility file received from Vaya. This file is loaded into the trip intake platform and automatically verifies members at intake, verifies that the reason for the trip is a covered service or benefit, and verifies if the member is within the established limitations. When ModivCare is unable to verify these pieces of information, it refers the member's trip to Vaya so that a decision can be made and Vaya can send out the appropriate denial notice or provide prior authorization so ModivCare can complete the trip scheduling.

The ride request is sent to or called into ModivCare for scheduling with an approved network provider. Urgent requests are prioritized, and immediate outreach is made to transportation providers based on service area and capacity to ensure trips are scheduled within required timelines and best efforts are made to arrange transportation in these cases. ModivCare also has a dedicated team that works directly with medical providers and facilities to manage members requiring recurring trips or acute care needs such as dialysis, chemotherapy, and behavioral health.

ModivCare's MTCs are trained to handle requests for services expeditiously and professionally in support of Vaya's Complex Care Managers to improve the overall transportation experience for its members. ModivCare offers several methods for sending transportation ride requests, including but not limited to dedicated phone lines, email access, and direct on-line access via web-based dashboards for real-time scheduling.

- **Phone:** The member or Vaya calls into the ModivCare toll-free, dedicated number and provides the necessary information for entry into ModivCare's system.
- **Fax:** Vaya or the medical facility faxes the necessary ride request information to ModivCare where it is retrieved and entered into ModivCare's system.
- **Email:** Vaya or the medical facility emails the necessary ride request information to ModivCare. An MTC retrieves the information and enters the ride request into ModivCare's system.

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

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

Member Access to NEMT Services

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

- Members are not required to make transportation requests more than two (2) days in advance;
- Members are not required to make transportation requests in person; and
- Urgent transportation services are exempt from any advance-notice requirement.

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

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

No-reject Requirements

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

Notification of Changes in Address

It is the Provider's responsibility to update any and all address changes related to claims, including site(s) of service and billing office location(s) by making these changes or updates 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.

SECTION 7 | Telehealth

Vaya supports broad access to the health care services managed by Vaya from eligible providers who are not at the member's location, using electronic communications system, including real-time interactive audio-visual communication and virtual communications. Services may be provided to members via telemedicine when equivalent in-person (face-to-face) services are not available or if members prefer this modality. Telehealth services are intended to overcome geographic, transportation or other barriers, to connect members and providers. DHB has a Telemedicine and Telepsychiatry Clinical Coverage Policy which provides details of the requirements for provision of telemedicine services and can be found on the NCDHHS website.

Telemedicine is a covered plan benefit subject to limitations and administrative guidelines. Telemedicine is defined as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located for the purpose of evaluation, diagnosis, or treatment. Telemedicine services provide the Member with enhanced healthcare services, the opportunity to improve health outcomes, and information when meeting face-to-face is unavailable. Beneficiaries are not required to participate in telemedicine or telepsychiatry.

Vaya will provide reimbursement for services covered in your contract with us and provided through telemedicine, when appropriate, and in an amount, duration, and scope to the same extent the services would be covered if provided through a face-to-face (in-person) encounter with a practitioner. Telemedicine will be reimbursed when service requirements are met and:

- The practitioner providing the telemedicine service is licensed within their scope of practice to perform the service
- Telemedicine 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 recipient and a practitioner
- A GT modifier is included on claims to indicate the delivery method was telemedicine

Medical professionals are encouraged to follow telemedicine guidance provided by the North Carolina Medical Board. Telemedicine can be a useful tool for increasing access to care, expanding specialty expertise and reducing patient cost. However, the medical board cautions that telemedicine providers will be held to the standards of care applicable to their area of specialty, with the same requirements for quality and outcomes as occurs with in-person care. For the most up to date guidance on Vaya's Telemedicine Coverage Policy, refer to https://providers.vayahealth.com/vaya_telemedicine_policy. For guidance from DHB on telemedicine, please refer to https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/telemedicine-and-telepsychiatry-clinical-coverage-policies.

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SECTION 8 | Network Adequacy and Access Standards

Policy Statement

Vaya's policy is to develop and maintain a sufficient network of high-quality service providers that meets member and community needs within available resources. Participation in the Vaya Closed Provider Network for mental health, substance use disorder and I/DD services is a privilege, not a right. Vaya established and implements a fair, impartial, objective, and consistent process for the enrollment and re-enrollment of service providers in the Vaya Closed Network that complies with applicable federal and state laws, rules and regulations and the requirements of the Tailored Plan and Medicaid Direct contracts. In accordance with N.C. Gen. Stat. § 108D-22, Vaya operates an open network for physical health and pharmacy services and will not exclude any of these providers from its network except when a provider refuses to accept network rates. Vaya's networks include providers who use evidence-based and best practices, practice a commitment to high-quality care and treatment that improves member outcomes, adhere to ethical and responsible practices, robustly protect member rights, and meet Vaya's business, operational and network development needs. Vaya is committed to the achievement of positive outcomes for members, as well as member satisfaction. We depend on our Network Providers to offer high-quality services and demonstrate accountability for the wellbeing of Vaya Health Plan members.

Background: Closed Behavioral Health Network

When Vaya began operation of the previous combined 1915(b)/(c) Medicaid Waiver in July 2012, providers of behavioral health and I/DD services who submitted a timely application, met Vaya credentialing criteria, were in good standing with NCDHHS and had billed for services delivered to Vaya members in the 60 days prior to their application were offered a contract for participation in the Vaya Closed Provider Network. On October 1, 2013, Vaya and Western Highlands Network (WHN) consolidated with Vaya as the surviving entity, and providers enrolled and in good standing with WHN were offered contracts with Vaya. Similarly, when Vaya consolidated with Cardinal Innovations effective January 1, 2022, providers enrolled and in good standing with both Vaya and Cardinal were offered contracts with Vaya. These are referred to as "open enrollment" periods. Subsequent provider contract extensions or renewals and new applications for participation in the Vaya Closed Network are subject to Vaya's selection and retention criteria and NCDHHS credentialing and re-credentialing requirements.

Federal regulations require Vaya to maintain a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Medicaid enrollees served by Vaya. When the 1915(b)(c) Medicaid Waiver was approved, CMS exempted North Carolina from complying with the provider

"freedom of choice" requirements under the Social Security Act. This waiver is balanced by Vaya's responsibility to ensure accessibility of services. NCDHHS monitors the adequacy of our network through the annual Network Access Plan for Medicaid and Network Access Plan for State-funded Services. We are not required to contract with providers beyond the number necessary to meet the overall service needs of our members, except for physical health providers as noted above.

There is no right under federal or state law for any provider to participate in our Closed Provider Network. The only exceptions are for emergency services or when there is no Network Provider available to provide medically necessary covered services to a particular individual. In accordance with 42 CFR 438.206 Vaya is not required to review the qualifications and credentials of Providers that wish to enroll in the Closed Network if Vaya has enough Providers with the same or similar qualifications and credentials to provide adequate access to all services. Ultimately, Vaya's goal is to achieve integrated, collaborative care across our network, develop provider expertise in evidence-based and best practices, and establish data-driven outcomes and performance measures to ensure that the system is meeting the health care needs of the individuals we serve.

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

Network Access Plan

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

Primary Care Providers

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

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

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

- Prior PCP assignment
- Member's claims history

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

Vaya informs existing members of a new PCP assignment through US mail within seven business days of the change. This notification includes a replacement member identification card, provided free of charge, with the new PCP name, physical address and phone number. This information is also available through the member portal.

Members can change their PCP without cause twice per year. Members have 30 days from receipt of annual notification of PCP assignment to change their PCP without cause (1st instance) and may change their PCP without cause up to one time per year thereafter (2nd instance). Members may change their PCP with cause at any time. When the PCP has failed to furnish accessible and appropriate medical care, services or supplies to which the member is entitled, this constitutes appropriate cause. Examples include, but are not limited to, the instances below:

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

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

PCPs may remove a member from their panel. When a PCP wishes to remove a member from their panel, the PCP must notify Vaya's Member and Recipient Call Center to trigger the re-assignment process for the member. The PCP must also send a letter to the member informing them of:

- The reason for removal from their panel (e.g., repeated history of no shows or tardiness, stolen property, ethical concerns, hostility/threats towards PCP or staff within the PCP office, etc.)
- 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 Call Center to request re-assignment of a PCP.

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

Network Adequacy and Accessibility Standards

To ensure that members and recipients have timely access to covered health care services, Vaya ensures its network meets the time and distance standards established by CMS, DHB and DMH/DD/SAS. If the Department issues any new standards, either through an amendment or as directed through formal notice, Vaya will comply with the new standards adopted. Vaya's Provider Network for Medicaid services consists of hospitals, physicians, advanced practice nurses, behavioral health mental health and SUD) treatment providers, I/DD and TBI providers, emergent and non-emergent transportation services, safety net hospitals and other provider types necessary to support the needs of Members. 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

Our Closed Provider Network for state-funded services consists of mental health, SUD, I/DD and TBI providers, Three-Way Contract inpatient care providers and all other provider types necessary to support the needs of Recipients.

For purposes of network adequacy, for physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children) services are those provided to a member who is less than 21 years of age. For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a

member who is less than 18 years of age. These standards are measured through multiple mechanisms throughout the year, including geo-access mapping (at least annually), monthly reviews of service availability, our annual Community Needs Assessment Survey and committee review of our service gaps reporting form.

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

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

Time and Distance Standards

Service Type	Urban Standard	Rural Standard
Primary Care	Greater than or equal to two providers within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two providers within 30 minutes or 30 miles for at least 95% of members
Specialty Care	Greater than or equal to two providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	Greater than or equal to two providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Hospitals	Greater than or equal to one hospital within 30 minutes or 15 miles for at least 95% of members	Greater than or equal to one hospital within 30 minutes or 30 miles for at least 95% of members
Pharmacies	Greater than or equal to two pharmacies within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two pharmacies within 30 minutes or 30 miles for at least 95% of members
OB/GYN	Greater than or equal to two providers within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two providers within 30 minutes or 30 miles for at least 95% of members
Occupational, Physical, or Speech Therapists	Greater than or equal to two providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	Greater than or equal to two providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members

Time and Distance Standards		
Outpatient Behavioral Health Services	Greater than or equal to two providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of members *Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*	Greater than or equal to two providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members *Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*
Location-Based Services (Behavioral Health)	Greater than or equal to two providers of each service within 30 minutes or 30 miles of residence for at least 95% of members *For Medicaid Direct* recipients this includes Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment *Child and Adolescent Day Treatment Services: Not subject to standard*	Greater than or equal to two providers of each service within 45 minutes or 45 miles of residence for at least 95% of members *For Medicaid Direct* recipients this includes Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment *Child and Adolescent Day Treatment Services: Not subject to standard*
Crisis Services (Behavioral Health)	Professional treatment services in facility-based crisis program: The greater of: • 2+ facilities within the Vaya service region OR • 1 facility within the Vaya service region per 450,000 total regional population (as estimated by combining NC OSBM county estimates). Facility-based crisis services for children and adolescents: greater than or equal to 1 provider within the Vaya service region Non-Hospital Medical Detoxification: greater than or equal to two providers within the Vaya service region Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal: greater than or equal to 1 provider of each service within the Vaya service region All other crisis services: greater than or equal to one provider of each crisis service within the Vaya service region *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard*	

Time and Distance Standards		
Inpatient Behavioral Health Services	Greater than or equal to one provider of each inpatient behavioral health service within the Vaya region	
Partial Hospitalization (Behavioral Health)	Greater than or equal to one provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	Greater than or equal to one provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	Greater than or equal to two providers of clinically managed low-intensity residential treatment services within the Vaya region	
All State Plan LTSS (except nursing facilities)	Vaya is required to have at least two LTSS provider types (home care providers and home health providers, including home health services, private duty nursing services, personal care services, and hospice services) that are identified by distinct NPI, accepting new patients and available to deliver each State Plan LTSS in every county.	Vaya is required to have at least two providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
Nursing Facilities	Greater than or equal to one nursing facility accepting new patients in every county.	Greater than or equal to one nursing facility accepting new patients in every county.
Community/Mobile Services	Greater than or equal to two providers of community/mobile services within the Vaya service region. Each county in the Vaya service region must have access to greater than or equal to 1 provider that is accepting new patients.	

Time and Distance Standards	

Residential Treatment Services	• *Residential Treatment Facility Services:* Access to greater than or equal to one licensed provider within the Vaya service region
	• *Substance Abuse Medically Monitored Residential Treatment*: Access to greater than or equal to one licensed provider within the Vaya service region
	• *Substance Abuse Non-Medical Community Residential Treatment:*
	  ○ Adult: Access to greater than or equal to one licensed provider within the Vaya service region
	  ○ Adolescent: Contract with all designated CASPs within the Vaya service region
	  ○ Women & Children: Contract with all designated CASPs within the Vaya service region
	• *Substance Abuse Halfway House:*
	  ○ Adult: Access to greater than or equal to one male and one female program within the Vaya service region
	• Adolescent: Access to greater than or equal to one program within the Vaya service region
	• *Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard

1915(i) HCBS	• *For Medicaid Direct* recipients: Community Living & Support, Individual and Transitional Support, Respite, and Supported Employment (for IDD and MH/SUD): greater than or equal to two providers of each (i) Option service within the Vaya service region
1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living:* greater than or equal to 2 providers of each Innovations waiver service within the Vaya service area. • *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:* greater than or equal to 1 provider of each Innovations waiver service within the Vaya service region. • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification:* Not subject to standard

DEFINITION OF SERVICE CATEGORY for Behavioral Health Time and Distance Standards	
Service Type	**Definition**
Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children)
Location-Based Services (Behavioral Health)	• Psychosocial rehabilitation (adult) • SA Comprehensive Outpatient (adult) • SA Intensive Outpatient Program (adults and children) • Opioid treatment (adult)
Crisis Services (Behavioral Health)	• Adult facility-based crisis • Child facility-based crisis • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult) • Clinically managed residential withdrawal management
Inpatient Behavioral Health Services	**Inpatient Hospital – Adult** • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds **Inpatient Hospital – Adolescent / Children** • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)
Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	• Clinically managed low-intensity residential treatment services

DEFINITION OF SERVICE CATEGORY for Behavioral Health Time and Distance Standards	
Residential Treatment Services	• Residential treatment facility services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID
Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment
1915(i) HCBS	• Supported Employment • Individual Support • Respite • Community Living and Support • Community Transition
1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

9

SECTION 9 | Billing and Reimbursement

This section provides a high-level overview of the provider billing and reimbursement process. For questions about claims or reimbursement issues, please contact us at 828-225-2785, ext. 2455, or at Claims@vayahealth.com.

Billing Prerequisites

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

- **Enrollment and member ID:** As explained in Section 6 of this Manual, the individual must be eligible for and enrolled in a Vaya Health Plan for a claim to be processed. The member ID number identifies the specific individual receiving the service and is assigned by the MCIS. For the provider to obtain this number, the individual must be successfully enrolled into a Vaya Health Plan. All claims submitted with incorrect member ID numbers, or for members whose enrollment is no longer active, will be denied.
- **Medical necessity:** All services paid with public funds must meet documented medical necessity criteria.
- Prior authorization: As outlined in Section 3 of this Manual, certain services must be authorized by Vaya prior to service delivery and claims submission. Vaya's claims adjudication system is specifically designed to verify authorization and other eligibility edits prior to reimbursement.
- **Coordination of Benefits:** Vaya is the payor of last resort 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 payment must be exhausted prior to billing Vaya for services rendered. If the member is eligible, state funds must be exhausted prior to billing Medicaid.
- **NPI (National Provider Identifier) and taxonomy:** All providers are required to obtain an NPI number to submit billing on the 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 that provider names, billing addresses, site addresses, NPI numbers and taxonomy information submitted to Vaya are verified and accurate and exactly match the information in the state of North Carolina's Medicaid Management Information System (MMIS), known as NCTracks. Failure to adhere to this requirement will result in claims denial or recoupment.
- **Documentation and service delivery requirements:** Network Providers are responsible for ensuring that services are delivered and documented in accordance with Controlling Authority outlined in your contract, including, but not limited to, DHB Clinical Coverage Policies and the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Please be aware that Medicaid regulations do not allow payment for

services delivered to inmates of public correctional institutions. There are also restrictions concerning payment for services delivered to people admitted to facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMDs). This may include some state facilities, private hospitals, ACH and Family Care Home settings. It is your responsibility to know whether a member is admitted to an IMD at the time-of-service delivery.

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

Authorization Specifics

- **Date of Service (DOS):** Each authorization will contain a unique number, start date, and end date. Only claims with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.
- **Type or code:** Each authorization will indicate the specific service or service code that is authorized. Each service will be validated against the authorization to make sure that the service billed matches the service authorized. Claims that fall outside of these parameters will be denied.
- **Units:** Each authorization will indicate the maximum number of units of service authorized for the time period in question. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits. Network Providers must establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.
- **Exceptions:** There are certain services that do not require authorization at all or do not require prior authorization for an initial service period, referred to as the "pass-through" period. These services are limited in scope, and the pass-through limits are applied per member, not per provider. Section 3 of this Manual details services that do not require authorization or have a pass-through limit. Once the pass-through limit is reached for a member, then all claims submitted without an authorization will be denied. Network Providers must be constantly aware of this issue to avoid denied claims.

Claims Submission

METHOD

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

- Basic benefit services, outpatient therapy, enhanced services, Innovations Waiver services and non-Medicaid residential and other daily and periodic services must be submitted using the American National Standards Institute ANSI 837P (professional) format or the electronic CMS 1500 form if billing through the Vaya system Provider Portal.
- Inpatient, therapeutic leave, Medicaid-funded residential services, outpatient revenue codes and ICF-IID services must be submitted using the ANSI 837I (institutional) format or the electronic UB04 form if billing through the MCIS Provider Portal.
- Paper claims will only be accepted from out-of-network hospitals or physician groups who submit claims for services delivered in an emergency department setting. These providers will be required to submit an accurate CMS 1500 or UB04 billing form with the correct data elements.

TIMEFRAMES

For emergency department and inpatient facility claims, all claims must be submitted within 180 days of the date of discharge, unless otherwise specified in your contract. In general, all other claims must be submitted within 180 days of the date of service. **Claims in which Vaya is the secondary payor must be submitted within 90 days of the date you receive a denial from a first- or third-party payor.** In the case of retroactive Medicaid eligibility, the timely filing requirement of 90 days is measured from the date that member eligibility is determined by NCDHHS. **Claims submitted outside of these timeframes will be denied.** Claims must be submitted no less than monthly. Network Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule in conjunction with the checkwrite schedule available on our website.

837 FILE SUBMISSION

Network Providers who wish to submit using an 837 file must complete training, successfully submit, and receive test files, and execute a Trading Partner Agreement. Training and additional information is available at https://providers.vayahealth.com. 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. DHB utilizes 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 provides the following HIPAA transaction files back to Providers: 999 (an acknowledgment receipt), 824 (a line-by-line acceptance/rejection response) and 835 (an electronic version of the remittance advice).

RATES

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

provider who accepts a patient as a Medicaid patient agrees to accept Medicaid payment, plus any authorized deductible, co-insurance, co-payment, and third-party payment as payment in full for all Medicaid covered services or supplies provided as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2).

Vaya will make payments for Tailored Care Management according to the Provider Payment requirements. Additionally, Vaya pays minimum medical home fees to all AMH practices and pays additional Tailored Care Management fees to AMH+ practices. Tailored Care Management fees differ based on a member's acuity level. Vaya collaborates with AMH+ and CMA practices to design and support innovations in care delivery, data sharing, and payment models according to each AMH+/CMA's strategies, capabilities, and, most importantly, member needs and preferences.

SITES AND SERVICES

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

CODES AND UNITS

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

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

For more information about coding and ICD-10 implementation, please see https://providers.vayahealth.com.

Coordination of Benefits

Medicaid is the payor of last resort. Providers are required to collect all first- and third-party funds prior to submitting claims to Vaya for reimbursement. First-party payors are the members or their guarantors. Third-party

payors are any other funding sources that can be billed to pay for the services provided to the member. This can include Medicare, third-party (private) insurance coverage through a non-custodial parent, an employer or the federal Health Insurance Marketplace, worker's compensation, disability insurance, employee assistance program (EAP), court-ordered services paid for by the court or another program, non-custodial parent pursuant to a custody order, liability judgment (e.g., vehicle accident), etc.

As discussed in Section 6 of this Manual, Network Providers must conduct a comprehensive eligibility determination process whenever a member is enrolled. You must also regularly monitor and update eligibility information if circumstances change for a particular member. All first- and third-party payors must be added to the member's record by doing a client update in the MCIS.

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

If the member is eligible for non-Medicaid services, those funds must be exhausted prior to billing Medicaid. The MCIS can validate third-party payors and deny or adjust the claim. For out-of-network hospitals and physician groups permitted to file paper claims with Vaya, the provider is required to submit copies of the ERA or EOB with the claim form to Vaya. If you receive reimbursement from a first- or third-party after a claim is submitted to Vaya, you must notify us and submit reimbursement within 30 days of receipt of the first- or third-party funds.

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

Remittance Advice and Claims Inquiries

The ERA is the standard method of communicating back to providers exactly how each claim is adjudicated. ERAs will be available in the download option of the MCIS following each checkwrite and will report whether claims are approved or denied and the reason code for each denial. HIPAA regulations require Vaya to supply providers who submit 837 files with an ERA known as the 835. The 835 will electronically report claims status and payment or denial information.

Inquiries regarding the status of claims should be directed to your assigned Vaya Claims Specialist or other Claims staff at 828-225-2785, ext. 2455, or Claims@vayahealth.com. The process for appealing Vaya's denial of any claims is outlined in Section 11 of this Manual.

Network Providers are directly responsible for management of account receivables. 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 IRS or N.C. Department of Revenue.

Provider claims are processed and paid in accordance with the NC Medicaid timeframes outlined in the Vaya Health contract with DHB, Section 1902(a)(37)(A) of the Social Security Act and 42 CFR § 447.45 as follows:

- Within 18 calendar days after Vaya receives a clean claim or invoice from a provider for a medical claim, Vaya shall either:
    - Approve payment of the claim/ invoice;
    - Deny payment of the claim/ invoice; or
    - Determine that additional information is required for making an approval or denial.
- Within 14 calendar days after Vaya receives a clean claim or invoice from a provider for a pharmacy claim, Vaya shall either:
    - Approve payment of the claim/ invoice;
    - Deny payment of the claim/ invoice; or
    - Determine that additional information is required for making an approval or denial.

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

If any approved claim is not paid to a provider, including, but not limited to, AMH+ practices and CMAs, within the required time period, interest will be accrued to be paid to the provider at the annual rate of 18% of the claim amount beginning on the date following the day on which the payment should have been made. In addition to the interest on late payments Vaya will pay the provider, including, but not limited to, AMH+ practices and CMAs, a penalty equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid. Please note that Vaya is not subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k). The total accrued interest amount is remitted to the provider in the calendar month following the payment of the claim. 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 electronic transfer or other actual delivery of the payment to the provider. Any interest paid to a provider is not to be paid with funds allocated to pay for health care services.

Repayment of Funds Owed to Vaya or NCDHHS

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

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

reimbursement. You must either file a void claim or replacement claim, or you may choose to complete a Claims Adjustment Request Form. The form and instructions are posted at https://providers.vayahealth.com. Upon receipt of the form, Vaya will make adjustments in the system and those adjustments will appear on your next RA.

If Vaya determines that you were reimbursed for a claim or portion of a claim that should be disallowed because of an error or omission unrelated to fraud, waste, or abuse, including encounter claims denied in NCTracks, we will readjudicate such claims and recoup the overpayment from your claims payments. It is the Provider's responsibility to update any and all address changes related to claims, including site(s) of service and billing office location(s) by making these changes or updates in NCTracks. The RA will identify any such adjudication or recoupment. There is no right to request reconsideration when claims are disallowed because of error or omission.

If you receive a written notice that Vaya identified an overpayment based on fraud, waste, abuse, overutilization, or non-compliance with your contract, including Controlling Authority, you must remit the amount owed within 30 calendar days of the notice, unless you submit a timely request for reconsideration as outlined in Section 11 of this Manual or request in good faith a payment plan. Providers must submit a formal written request for reconsideration, to the address specified in the notification letter, within thirty (30) calendar days from the date of the letter informing them of Vaya's intended action. If you fail to timely file a request for reconsideration or fail to timely submit requested financials and/or agree to a payment plan within a reasonable time after requesting a payment plan, we may recoup the funds owed from your claims payments without further notification. We are not required to approve any request for a payment plan. All payment plans will require a signed agreement and may require a promissory note and security.

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

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SECTION 10 | Treatment Coordination and Discharge Planning Requirements

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

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

- Permit transition staff, including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator to engage in and help coordinate the discharge planning process.
- Notify Vaya of member admissions/pending discharges and contact the assigned organization providing Tailored Care Management (if applicable) to integrate the organization into the discharge/transition planning process.
- Share relevant information (including the member's current Care Plan/ISP, initial and final discharge plans, and medical information when applicable) among transition/discharge planning team members and the member's care team if applicable. If a member declines to permit access to Vaya or the provider, this must be documented in the medical record.
- Establish relationships with AMH+ practices and CMAs to facilitate care transitions.
- You must regularly schedule treatment and transition planning meetings for members in 24-hour inpatient care.
- You must provide Vaya, the member's Tailored Care Manager and the member's BHCH, or other designated community behavioral health provider, with at least 24 hours prior notice of the date, time and place of any treatment team or discharge planning meeting regarding a Vaya Health Plan member. If a member declines to permit notice to Vaya or the provider, this must be documented in the medical record.
- You must notify Vaya, the BHCH and/or the designated community behavioral health service provider at least 24 hours prior to the intended date and time of any discharge of a member from inpatient care. If a member declines to permit notice to Vaya or the provider, this must be documented in the medical record.

- If preferred formulary medication was used previously and proven ineffective for a member, you may request prior authorization for a non-preferred medication. Prior authorization can be requested by calling the Pharmacy Service Line (1-800-540-6083) or by submitting the appropriate form found in the Provider Portal. The prior authorization process will include a review of the member's medical history and preferred treatment alternatives that can facilitate ongoing medication adherence and effective treatment.
- In the event of inpatient behavioral health treatment, once the discharge date is determined, you must schedule a follow-up appointment with the BHCH or designated community behavioral health service provider (if the member has an active treatment relationship pre-dating admission) or request that Vaya's Member Services Department do so. The follow-up appointment must be scheduled to occur within five days of discharge.
- At the time of discharge, you must complete the discharge section of the patient module in the MCIS and provide the member, Vaya, the Tailored Care Manager and the assigned community behavioral health provider with the following critical patient discharge information:
    - Reason for hospitalization
    - Significant findings
    - Procedures and treatment provided
    - Admission and discharge diagnoses
    - Member's demographic information
    - Member's discharge condition (including level of risk to self/others)
    - Discharge medications and Medication Reconciliation Form (dosage and amounts, when refills needed)
    - Recommended follow-up care (both medical and psychiatric)
    - Recommended revisions to CCP (if any)
    - Name of discharging physician with contact information
    - Any other information requested by Vaya at the time of discharge

Additional transitional care management functions include:

- The development of a ninety (90) day post discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff and the member's care team, that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.
    - The ninety (90) day post-discharge transition plan must be implemented upon discharge and be an amendment to the Care Plan or ISP
    - To the extent feasible, a CMCA should be conducted to inform the ninety (90) day post-discharge transition plan.
    - The ninety (90) day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
        - Development of a ninety (90) day post-discharge transition plan is not required for all ED visits, but may be developed according to the care manager's discretion.
        - The assigned organization providing Tailored Care Management must:
        - Communicate with and provide education to the member and the member's caregivers and providers to promote understanding of the ninety (90) day post-discharge transition plan. Assist with scheduling of transportation, in-home services, and follow-up outpatient visits

with appropriate providers within a maximum of seven (7) calendar days post-discharge, unless required within a shorter timeframe. Ensure that the assigned care manager follows up with the member within forty-eight
    - (48) hours of discharge.
    - Arrange to visit the member in the new care setting after discharge/transition.
    - Conduct a CMCA within thirty (30) days of the discharge/transition or update the current assessment.
    - Update the member's Care Plan/ISP in coordination with the member's care team within ninety (90) days of the discharge/transition based on the results of the care management comprehensive assessment.
- Vaya will ensure that for individuals with I/DD or TBI, the assigned organization providing Tailored Care Management conducts relevant transitional care management activities in the following "life transitions"
    - Instances where a member is transitioning out of school-related services;
    - Instances where a member experiences life changes such as employment, retirement or other life events;
    - Instances where a member has experienced the loss of a primary caregiver or a change of primary caregiver; and
    - Instances where a member is transitioning out of foster care.
- Vaya submits its policies and procedures for transitional care management to DHB for review and approval, including the approach to working with members with LTSS needs, as part of its Care Management Policy

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

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SECTION 11 | Provider Disputes

Policy Statement

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

Scope

This dispute resolution process does not apply to appeals filed by a member, LRP or personal representative contesting decisions of Vaya to deny, reduce, terminate, or suspend a covered service in accordance with N.C.G.S. Chapter 108D and 42 CFR Part 438, Subpart F. Those decisions are handled through Vaya's member reconsideration and appeals process explained in section 3 of this Manual.

This dispute resolution process is available to Network Providers and Out of Network Providers.

Can a Provider appeal every dispute it has with Vaya?

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

- Refusal to process or denial of a request to participate in the Closed Network;
- Refusal to renew or extend a provider's participation as a Network Provider beyond the terms of such provider's network contract(s);
- Refusal to process or denial of a request to add a site or service to an existing network contract;
- Refusal to award a service, program and/or funding as part of any Vaya procurement process;
- Any agreed-upon adjustment to earnings targets for non-fee-for-service shadow claims;
- Issuance of a warning letter, educational letter, technical assistance letter, Report of Findings or Plan of Correction (POC) that does not change the provider's status within the Closed Network;
- A decision to place a provider on prepayment review;
- Formal report to oversight authorities of known or suspected violations, including, but not limited to, the following:
    - Federal Centers for Medicare and Medicaid Services, known as CMS (Medicaid or Medicare fraud);
    - DHB Program Integrity or the Medicaid Investigations Division of the N.C. Department of Justice (Medicaid fraud);

- Division of Health Service Regulation (licensure or healthcare personnel registry violations);
- DMH/DD/SAS (summary suspension and/or revocation of authorization to receive public funding for the provision of behavioral health and I/DD services);
- County Departments of Social Services (abuse, neglect and exploitation);
- Provider accrediting bodies;
- Practitioner licensure or certification boards; or
- Law enforcement.

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

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

What can be appealed?

This dispute resolution process is available to any Provider who wishes to initiate it in response to any of the following:

- Any Notice of Administrative Action, Overpayment or Sanction issued by Vaya against a Provider;
- An emergency contract suspension or suspension of referrals issued by the CMO against a Provider to protect the life, health, safety, or welfare of any member/ enrollee as described in Section 13 of this Manual;
- Final notification of a claim denial;
- Payment withholding of a 1/12 shadow claim payment regarding a non-Medicaid funded contract by and between Vaya and a Provider; and
- Any other significant dispute that cannot be resolved informally and which has direct implications for the Provider, unless excluded as described above.

Any requests for provider appeals concerning disputes that do not obviously fall into a category listed above will be reviewed by Vaya for determination of whether it is a valid dispute, and, if so, whether it should be categorized as administrative or clinical. If the appeal is determined to be invalid or untimely, Vaya will send you a written notification no later than fourteen (14) calendar days after the Reconsideration Review unless there are documented extenuating circumstances for the Network Provider or Vaya.

If the due date falls on a day the Vaya Administrative Office is closed (holiday, weekend, inclement weather, etc.), the notice will be issued the next day the Vaya Administrative Office is open. The letter will explain why the issue raised is not subject to the dispute resolution process, is untimely or is otherwise invalid.

Provider Appeal (Reconsideration) Overview

Reconsideration is the Provider's opportunity to present documents and information disputing the findings identified by Vaya. All documentation the provider wishes to be considered for reconsideration must be submitted electronically at the same time the Reconsideration Request Form is submitted. There are three tracks for provider appeals: Administrative Actions, Provider Sanctions and Claim Denials. Each track offers a mechanism for the provider to request a Reconsideration Review by a three-person panel that was not involved in the initial or prior decision of the subject of the dispute. Providers may request an appeal Review by at least one level of panel review. For requests to appeal a Provider Sanction or a Claim Denial, the provider may request review from a first- and second-level panel.

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

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

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

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

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

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

How do I request an appeal?

A Provider Appeal Request Form ("Form") will be included with any written notification of an administrative action or sanction you receive from Vaya ("Notice"), except for claim denials, which are discussed below. You must submit a signed, fully completed Reconsideration Request Form ("Form") with all documentation to support your position within thirty (30) calendar days of the date of the applicable notification. The Form must be signed by the disputing practitioner or an authorized representative of a provider organized as a corporate entity.

You must select the type of panel meeting you prefer (telephone, video conferencing, desk review), and identify all persons you plan to bring to the meeting. Only one provider appeal request may be submitted per dispute or Notice.

The Form and all documents you wish to be reviewed with your reconsideration must be sent electronically to Provider.Reconsiderations@vayahealth.com.

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

What happens after I submit an Appeal request?
If we receive a signed, complete, timely request, we will send you a written notification with the date, time and location of the panel meeting. If you are represented by legal counsel, the notice will be sent to your legal counsel.

How do I submit additional documentation for consideration by the panel?
Any documentation you wish to be considered by a panel must be submitted electronically

- For all Provider Appeals, documentation supporting the justification for provider's position must be submitted at the same time the Reconsideration Request Form is submitted.
- For claim denials, documentation for the first level review must be submitted with the request for reconsideration. Documentation for the second level review must be submitted at least five (5) days prior to the date of the scheduled second level review.

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

Panel Meeting Process

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

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

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

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

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

Do I need an attorney?
We cannot make that decision for you. You may want to consider the amount or issue at stake. A Vaya attorney is usually present at all panel meetings, except for claims denial reconsiderations. However, panel meetings are informal and non-adversarial. Witnesses are not sworn, and cross-examination is not permitted.

You must notify us in advance of the number of persons who will be present.

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

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

What happens at a video conference meeting?
The panel facilitator will provide an opening statement explaining the agenda and requesting all parties present to state their name and title. A Vaya staff person will first present our view of the dispute in an objective manner. You may then present a narrative summary of the facts, evidence or arguments in support of your position. It is helpful to refer to documentation or laws, rules, regulations or policies in support of your position.

Throughout the presentations the panel members will review relevant documentation and may ask you questions. Vaya's legal counsel may provide advice or counsel to Vaya staff or panel members at any point in the process. At the end of the meeting, the facilitator will ask you to sign an attestation acknowledging that the agenda and role(s) of each person present were explained, that all parties were given equal opportunity to present their information in a fair and equitable manner, and that the anticipated timing for a written decision was shared.

What happens at a telephonic panel meeting?
A telephonic meeting generally follows the same process as a video conference meeting. We will send you the attestation in advance of the meeting and ask that you return it via email immediately following the meeting.

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

How and when does the panel reach a decision?
Following the meeting, the panel will deliberate and vote on a determination to uphold, revise or overturn the decision or pend for more information. Vaya legal counsel may be present during the deliberation to answer legal questions. All three panel members must be present for a vote to take place, and determinations are reached by majority vote. Vaya's Executive Leadership Team (ELT) is authorized to overturn or revise the decision of any Vaya reconsideration panel.

Following panel deliberations, the facilitator shall issue a decision notice based on instruction from the panel or ELT and following review by Vaya legal counsel. The written decision will be sent to you via secure electronic transmission no later than 14 days after the panel meeting, excluding official Vaya holidays, unless additional time is needed due to extenuating circumstances. The date of the decision letter is the date of the final decision by Vaya.

Are panel meetings confidential?
Vaya is a government entity subject to the N.C. Public Records Act, N.C.G.S. Chapter 132. While there are some exceptions (for example, sensitive information or competitive health information), some of our written material can be produced in response to a public records request. We are also required to notify DHB whenever we terminate or suspend a provider's participation in our network. However, to protect confidentiality, uphold professionalism and preserve objectivity for second-level panels, panel members and participating staff will refrain from discussing the review with providers, peers or colleagues who are not on the panel or directly participating in the process, except as necessary to respond to requests from members or their families/ caregivers impacted by the dispute.

Is the panel decision final?
Other than first-level claim decisions as outlined in the "Disputing Claim Denials" in Section 11 of this Manual, panel decisions on **administrative** actions are final and may not be appealed any further with Vaya. However, if you are not satisfied with the first-level decision issued about a **sanction**, you may request reconsideration by a second level panel within 10 days of the date of the decision. If you do not request a second-level panel review by 5:00 p.m. on the 10th day after the date of the first-level decision, the sanction decision will be final.

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

How does the second-level panel process work?
The second-level panel will include different panel members, but otherwise the process is the same. Within 14 days from the date we receive a signed, complete, timely request for reconsideration of a first-level sanction

decision, excluding official Vaya holidays, we will schedule a second-level panel, unless there are documented extenuating circumstances for you or Vaya. We will notify you of the date and time of the scheduled panel meeting in writing.

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

Disputing Claim Denials

What is a claim denial?

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

Where can I find the Reconsideration Request Form?

The Level 1 Request for Reconsideration of Claim Denial Form ("Level 1 form") can be found on the Vaya website or may be requested from a Vaya representative. The submitted form must include specifics regarding the claim(s), including, but not limited to, the member's name, member record number, date of service, service code, claim header information and all other relevant information regarding the claim.

Level 1 claim denial reconsideration forms must be submitted electronically to be considered valid. All requests should be sent to ClaimsReconsideration@vayahealth.com. If a signed, complete Level 1 form is not received within the required 30-day period, Vaya's action to deny the claim is final without further written notification.

When will a panel meeting be scheduled?

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

What if I disagree with the Level 1 decision?

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

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

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

If a Level 2 review is held, the Level 2 panel will issue a decision to uphold, overturn or adjust the Level 1 Reconsideration decision based on the information available. The panel will issue a written decision within 14 days from the date of the Level 2 panel Review. The Level 2 Claim Denial Decision is final and may not be appealed further with Vaya. Please consult with your legal counsel on options for appealing Vaya's final decision.

Provider Complaints (Grievances)

Any Provider who is dissatisfied with a Vaya has the right to file a complaint which is also referred to as a grievance. A grievance is an oral or written expression of dissatisfaction by or on behalf of a member or recipient about any matter other than an Adverse Benefit Determination, including but not limited to quality of services, Vaya or provider employees, or Vaya or provider practices.

Can any provider file a complaint?
Yes. Any provider may file a complaint for any issue or concern they have with Vaya Health or other Vaya Network Provider. Vaya encourages every provider organization to address concerns informally through Provider Network Operations or the Claims Administration Team, but this step is not required, and a formal complaint may be filed at any time. Vaya will address all complaints in a timely, fair, consistent manner.

You may reach the PNO Department by e-mail at providerinfo@vayahealth.com or by calling 828-225-2785, ext. 1512.

How do i file a complaint?
Vaya follows a "No Wrong Door" approach for complaint submission. Providers may report concerns as follows:

- Electronically using the Vaya EthicsPoint portal (allows for anonymous reporting);
- Orally to any Vaya employee, who will then file the complaint in EthicsPoint on their behalf;
- By contacting 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 1-800-849-6127.
- By calling the Grievance Resolution Incident Team at 828-586-5501, extension 1600.By sending an email to resolutionteam@vayahealth.com.
- Via hand-delivery, fax, email, or mail to any Vaya administrative office location or staff member.

How will Vaya look into my complaint?
Efforts to resolve a complaint may include, but are not limited to one or more of the following:

- Phone interviews with the filer to obtain additional information or clarification;
- Consultation with Vaya staff, including the General Counsel, Chief Medical Officer or other licensed clinicians or subject matter experts;

- Provider record request and record review; and
- Phone interviews with person(s) who have a legitimate role in the issue to be resolved.

How will i find out what happened to my complaint?

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

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SECTION 12 | Complaint or Grievance Investigation and Resolution Procedures

All Network Providers are required to implement and maintain an internal process to address any grievances, complaints or concerns related to services provided. This process must be in writing, well-publicized and communicated to all members and recipients upon admission to treatment and upon request. Any unresolved grievances, complaints or concerns, or violation of member and recipient rights should be reported to the Vaya Grievance Resolution & Incident Team (GRIT) by calling 828-225-2785 extension 1600 and/or by contacting the appropriate state or federal official:

NCDHHS Customer Service Center:

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

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

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

NCDHHS Office of Privacy and Security:

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

Office of the State Long Term Care Ombudsman:

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

N.C. Division of Health Service Regulation (Licensed Facilities)

- **Complaint Hotline:** 1-800-624-3004 (within North Carolina) or 919-855-4500
- **Complaint Hotline Hours:** 9 a.m. – 12 p.m. and 1 p.m. – 4 p.m. weekdays, except holidays.
- **Fax:** 919-715-7724
- **Mail:** 2711 Mail Service Center, Raleigh, NC 27699-2711
- **Online Reporting:** https://info.ncdhhs.gov/dhsr/ciu/filecomplaint.html

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

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

Vaya Health Plan members and recipients can also file a grievance or complaint directly with Vaya about any matter other than authorization decisions, either verbally or in writing. As a provider, you must publicize the process for contacting Vaya to report a grievance, complaint, concern, or potential rights violation:

- **Phone:** Call the Member and Recipient Service Line 1-800-849-6127
- **Phone:** Call the Vaya Compliance Hotline at 1-866-916-4255 (this option allows for anonymous reporting)
- Mail: Vaya Health, Attn: Grievance Resolution & Incidents Team, 200 Ridgefield Court, Asheville NC 28806
- **Email:** ResolutionTeam@vayahealth.com
- **Online through EthicsPoint:** vayahealth.ethicspoint.com (this option allows for anonymous reporting). EthicsPoint™, an online compliance intake platform, is used as a compliance concern and complaint/grievance reporting mechanism for members, community stakeholders, providers and Vaya staff. The EthicsPoint™ platform assigns an individualized report key to each case as well as a password, which must be maintained as staff at Vaya do not have access to update or retrieve passwords.

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

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

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

concern and resolution information. Network Providers are required to respond to requests for information from the GRIT within 10 days of a request for information. If you do not respond within this timeframe, a decision regarding the grievance or complaint will be made without your input and you may be referred for follow-up and potential sanction.

Based on the nature of grievances and complaints we receive, Vaya may also choose to investigate a Network Provider or make a referral to another agency, such as the Division of Health Service Regulation (for licensed facilities). Investigations may be announced or unannounced. More information about those investigations can be found in Section 13 of this Manual.

Vaya makes every effort to resolve member and recipient grievances and complaints within 30 days. Under federal law, we have up to 90 days to resolve a Medicaid grievance. Individuals who file a grievance or complaint receive written notification about the resolution and may appeal the findings. The appeal is reviewed internally by an appropriate Vaya staff member or licensed clinician and there is no right to appeal further (for example to NCDHHS or the Office of Administrative Hearings).

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SECTION 13 | Performance Improvement Procedures

Continuous Quality Improvement

Vaya is committed to working in collaboration with our Network Providers to achieve the highest standards of quality in service delivery. We understand the important role of quality improvement in promoting member safety and high-quality treatment. We maintain a strong commitment to continual improvement of our programs and services, as well as the services provided directly to members. We accomplish this by continually:

1. Monitoring member safety and quality according to an established standard
2. Assessing the ability to achieve these measurable standards
3. Improving member safety and quality by implementing targeted interventions

Vaya must comply with numerous quality, satisfaction, performance indicator and financial reporting requirements under our DHB and DMH/DD/SAS contracts, including requirements to measure and report indicators in the following domains: access, availability, quality of care, quality of services, appropriateness of services, system performance and satisfaction. Vaya may use your performance data for quality improvement activities when performance indicators are not met.

Vaya's Quality Management (QM) program utilizes a data-driven, outcomes-based Continuous Quality Improvement process that supports our goal to improve the health of North Carolinians. Through our QM and Performance Improvement (PI) program, Vaya applies an approach that is whole person centered and coordinated to address both medical and non-medical drivers of health. We are proud to be a quality-driven organization that adopts continuous quality improvement (CQI) activities across all functional areas. Our comprehensive QM/PI program utilizes a Plan, Do, Study, Act (PDSA) methodology for clinical performance improvement projects (PIPs) that allows us to monitor performance and measure the effectiveness of initiatives. This is an established system for testing a change by planning, taking action, observing outcomes, analyzing results and acting on what was learned. Vaya's QM Department partners with our Provider Network to conduct clinical studies aimed at impacting the Quadruple Aim.

The Department has developed a Medicaid managed care Quality Strategy to ensure the delivery of high-quality care and improved Member and Recipient outcomes. The Quality Strategy includes a set of quality metrics that will be used to assess performance and outcomes for Tailored Plans and their Network Providers. Vaya's QM Department will support Network providers during the initiation and implementation of interventions outlined in the Quality Strategy as part of our Provider Support Plan which will be updated annually. The plan will detail

provider support activities designed to advance the aims, goals, and objectives of the Quality Strategy and lead to care improvement efforts at a practice and regional level. The QM Provider Support Plan is posted online at https://providers.vayahealth.com.

Vaya maintains a Quality Improvement Committee (QIC) that includes representatives from Vaya staff, members and Network Providers. QIC develops an annual Quality Management Plan for the Vaya system with input and feedback from relevant stakeholders. The QM plan includes the Program Description, Evaluation and Workplan. Vaya makes this information available to Network Providers, practitioners, members and stakeholders on the Vaya website. A printed copy of the information can be provided upon direct request to Vaya. Providers can obtain a copy of this document on the Vaya website or by emailing provider.info@vayahealth.com.

The Board of Directors also maintains a Regulatory Compliance and Quality Committee that regularly hears reports on these measures. In addition, Vaya is routinely monitored by our accrediting bodies, the NCDHHS Intra-Departmental Monitoring Team (IMT), and an External Quality Review Organization (EQRO).

The continual self-assessment of services and operations, as well as the development and implementation of plans to improve outcomes for members, is a value and requirement for all Network Providers. You are required to be in compliance with all federal and state quality assurance and performance improvement standards, including, but not limited to:

1. The establishment of a formal quality committee to evaluate services, plan for improvements and assess progress made toward goals. The assessment of need, as well as the determination of areas for improvement, must be based on accurate, timely and valid data. Your quality assurance (QA) and quality improvement (QI) system will be evaluated through focused monitoring and post-payment reviews.
2. Maintenance and submission of client rights committee minutes, if applicable.
3. Development and execution of an annual Quality Improvement Plan, which will be evaluated through focused monitoring and post-payment reviews.
4. Participation in performance improvement projects required under our Tailored Plan contract.
5. Reporting of incidents and follow up, as needed.
6. Cooperation with Vaya's grievance, monitoring, and program integrity activities.
7. Active participation in provider and member satisfaction surveys.

Satisfaction Surveys

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

Monitoring to Ensure Quality of Care

Vaya must ensure the provision of high-quality services by our Network Providers. This includes monitoring member health and safety, conducting investigations, monitoring and resolving grievances and incidents, protecting member rights, ensuring provider qualification, assessing outcomes to determine efficacy of care, using evidence-based and best practices and implementing preventive health initiatives. We are also charged with conducting compliance reviews and audits of medical records, administrative files, the physical environment and

other areas of Network Provider service delivery, including cultural competency reviews. These monitoring activities are discussed in the next section.

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

- The Vaya SIU to review potential fraud, waste or abuse
- DHSR (licensure or healthcare personnel registry violations) or out-of-state licensure bodies
- DHB, DMH/DD/SAS or other behavioral health MCOs in North Carolina
- CMS (for potential fraud, waste or abuse of Medicare funds)
- County Departments of Social Services (abuse, neglect or exploitation)
- Provider accrediting bodies
- Practitioner licensure or certification boards
- Law enforcement

SITE REVIEWS OF UNLICENSED OR UNACCREDITED PROVIDERS

Site visits will be conducted, when appropriate, by DHB's credentialing vendor. Network Providers are required to meet the following standards, at a minimum, for office sites where members are seen:

- Physical accessibility: Sites are handicapped accessible.
- Physical appearance: Office site is well-maintained, neat and clean.
- Office hours are prominently posted.
- Adequacy of waiting and offices/examining room space:
    - Waiting and examining rooms are well-lit.
    - Adequate seating is available.
- Availability of appointments:
    - 24-hour, life-threatening emergency coverage is provided for members under your care.
    - Emergent care appointments are within two hours.
    - Urgent care appointments are within 48 hours.
    - Routine care appointments are within 14 days.
- Adequacy of treatment record-keeping:
    - Provider is in compliance with all Controlling Authority.
    - Medical records shall be maintained in a secure/confidential filing system.
    - Medical records shall not be commingled.
    - Medical records shall contain legible file markers.
    - Medical records are easily located.

Vaya Site Review Specialists also complete reviews of Unlicensed AFL sites annually or when a Provider requests to add or update a site in accordance with NCDHHS requirements.

POST-PAYMENT REVIEWS (PPRs)

Vaya evaluates Network Provider compliance and performance to evaluate clinical documentation to ensure services were provided appropriately, within established benchmarks and clinical guidelines, and that those services are consistent with pre-authorization (when required), relevant assessments and the person-centered plan/treatment plan.

PPR is a process that involves a retrospective review of a sample of services typically conducted as a desk review but may be conducted on site. Information from the member's record (including assessment information, person-centered plan/treatment plan and progress notes) is evaluated against medical necessity criteria. The outcome of these reviews may indicate areas in which additional provider training is needed, that services were provided that did not meet medical necessity and situations in which the member did not receive appropriate services or needed care.

Because Vaya strives to be transparent throughout the PPR process:

- You will be notified of the scheduled review date in writing 21-28 calendar days prior to the date of the review.
- You will be notified of the specific service records needed for the review no less than seven business days prior to the date of the review.
- Reviews will include an opening and exit conference. Any follow-up to be completed by the Network Provider or Vaya are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.** After the review is concluded, any additional information submitted will not be used to change any established scores or out of compliance findings, but it may be considered in implementation of a plan of correction (if required).
- You will be notified in writing of the results of the PPR within 15 days of completion of the review.

Vaya will issue a plan of correction or adverse action in response to a score below 85 percent on an audit tool, monitoring that reveals systemic compliance issues or any quality of care or quality outcome concerns.

FOCUSED MONITORING

We conduct focused provider monitoring: (1) in response to significant indicators and/or reported trends that you may not be in compliance with Controlling Authority identified in your contract, including, but not limited to, the 1115 Medicaid Demonstration Waiver, the 1915(c) Waiver, DHB Clinical Coverage Policies, DMH/DD/SAS Service Definitions, the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, N.C. Administrative Code provisions governing delivery of behavioral health and I/DD services and any other service-specific standards, contract or administrative requirements; (2) to verify your contract compliance; and/or (3) in response to priorities for compliance verification as identified by utilization, costs and needs. Focused monitoring may also be conducted in conjunction with NCDHHS divisions, other MCOs or other Vaya departments.

- A focused monitoring can be conducted as a desk review or as an announced or unannounced site review.
- On-site reviews will include an opening and exit conference similar to a PPR. Any follow-up to be completed by the Network Provider or Vaya will be reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.**
- You will be notified in writing of the results of the focused monitoring within 15 days of completion of the review.

GRIEVANCE AND COMPLAINT INVESTIGATIONS

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

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

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

WHAT IS A PLAN OF CORRECTION (POC)?

The POC is a written document developed by you in response to a Report of Findings from Vaya. The POC must specify how you will address each out-of-compliance finding, violation or deficiency identified by Vaya. The POC must be approved by Vaya as adequately addressing the issues in need of correction. Vaya will conduct monitoring to ensure that the plan is implemented and fully integrated into your operation(s) and that all deficiencies were corrected and are unlikely to re-occur. We follow the process and timelines outlined in the NCDHHS current Plan of Correction Policy available on the NCDHHS website at: https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/policies-and-procedures/current-plan-correction-policy . Failure to submit or implement an acceptable POC or substantially minimize or eliminate deficiencies may result in sanction up to and including termination from the network.

Suspensions for Health and Safety Reasons

Vaya is required by our accrediting body to suspend your contract if our CMO or another Senior Clinical Staff Person determines that a Network Provider may be engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any member. If a decision is made to suspend referrals or your contract for health and safety reasons, we will make best efforts to notify you within one business day of the decision. The notice will include the basis for our determination, the effective date of the suspension and

instructions to discontinue the delivery of services until further notice and direct members in urgent need of services to contact the Member and Recipient Service Line at **1-800-849-6127.**

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

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

Adverse Actions

We strive to ensure any adverse action issued against a Network Provider is fair, reasonable and consistent. We may issue an adverse action in response to any finding that you are out of compliance with applicable federal and state laws, rules, regulations, manuals, policies or guidance, this Manual, contracts between you and Vaya and any other applicable payor program requirements. Vaya must remove any provider from our claims payment system, and terminate the provider's contract within one (1) business day of receipt of a 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. In addition, Vaya must deny payment for dates of service after the date of termination from Medicaid.

Adverse actions issued by Vaya fall into two categories: Administrative Actions and Sanctions.

What is an Administrative Action?

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

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

What is a Sanction?

A Sanction is an action against a Network Provider, and/or its Owners and/or Managing Employees, based on professional competence or conduct or resulting in a change to your status within the Closed Network. Examples of potential sanctions include, but are not limited to:

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

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

- The provider violated a contractual, legal and/or administrative requirement, including, but not limited to, documentation, billing or other requirements set forth in DHB Clinical Coverage Policies and Manuals and DMH/DD/SAS Service Definitions and Manuals.
- The provider meets the "substantial failure to comply" standard as defined by 10A NCAC 26C .0502(6).
- The provider violated professional and/or ethical standards, including tolerating or covering up such violations on the part of its employees.
- The provider engaged in unlawful acts, including orchestrating, promoting, tolerating or covering up any illegal activity on the part of its employees.
- The provider is jeopardizing the health and safety of members.

Automatic (Immediate) Termination

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

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

Notification of Adverse Action

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

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

Incident Reporting

Vaya is required to monitor certain types of incidents that occur involving Category A and B Providers and other providers who operate within our region. An incident is an event which 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 upon a member. Incidents are classified into three categories according to the severity of the incident. Network Providers are required to document and maintain internal records of all Level I incidents and make them available upon request as well as submit the QM 11 Quarterly reporting form by the 10th day of the month following the reporting period. **Category A and B Providers are required to report all Level II and Level III incidents in the state's Incident Response Improvement System (IRIS) as explained more fully at 10A NCAC 27G .0604.** Providers must give Vaya verbal notification of a member's death within 24 hours for any member that has been seen within 90 days prior to their death. Failure to do so is a violation of your contract and the N.C. Administrative Code. Out-of-state providers who do not have access to IRIS must submit paper copies of the incident report to NCDHHS and to Vaya.

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

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

All Level III incidents that occurred while the member was receiving services require a formal internal team review process initiated within 24 hours and require that notification of the Level III incident be made to the GRIT within 24 hours by: facsimile to 828-398-4407, by email incidentreport@vayahealth.com or by calling 828-225-2785 and asking for an Incident Report Specialist.

Vaya receives and tracks all incident reports filed in IRIS that involve Category A and B providers operating in our region. Upon receipt, we review incidents for completeness, appropriateness of interventions and achievement of

short- and long-term follow-up for the member and the Network Provider's service system. If an incident reviewer determines corrections are needed, a request for corrections will be emailed to the individual that submitted the incident. All requests must be returned in a timely manner. Non-compliance with requests and timelines may result in a plan of correction in accordance with Vaya's Policies and Procedures.

All member deaths and Level III incidents will be reviewed by Vaya's Critical Incident Review Committee (CIRC), which is chaired by our CMO. The CIRC may request more extensive documentation regarding the member if deemed necessary. You must cooperate with this process and submit records as requested. Network Providers are required to develop and maintain a system to collect and track documentation on any incident that occurs in relation to a member. If concerns are raised related to the member's care or services, or your response to an incident, the CIRC will refer the matter for potential investigation.

- For more information about IRIS and your reporting responsibilities, please refer to: http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-incident-response-improvement-system.
- For IRIS resources, including the Incident Response and Reporting Manual and NC IRIS Technical Manual, please refer to: http://www.ncdhhs.gov/document/iris-resources.
- The GRIT is also responsible for receiving and responding to all grievance and complaints filed by or on behalf of a member as referenced in Section 12 of this Manual.

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SECTION 14 |

Interest and Penalty Provisions for Late or Under-payment by Vaya

If any approved claim is not paid to a provider, including, but not limited to, AMH+ practices and CMAs, within the required time period, interest will be accrued to be paid to the provider at the annual rate of 18% of the claim amount beginning on the date following the day on which the payment should have been made. In addition to the interest on late payments Vaya will pay the provider, including, but not limited to, AMH+ practices and CMAs, a penalty equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid. Please note that Vaya is not subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k). The total accrued interest amount is remitted to the provider in the calendar month following the payment of the claim. 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 electronic transfer or other actual delivery of the payment to the provider. Any interest paid to a provider is not to be paid with funds allocated to pay for health care services.

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SECTION 15 | Member and Recipient Rights and Empowerment

The protection and promotion of member and recipient rights and empowerment is a crucial component of our service delivery system. Vaya Network Providers must always respect member and recipient rights, provide members and recipients continual education regarding their rights, and support them in fully exercising their rights.

Member and Recipient Rights

Under the U.S. and N.C. Constitutions, N.C.G.S. Chapter 122C, Article 3, APSM 95-2: DMH/DD/SAS Client Rights Rules in Community Mental Health, Developmental Disabilities and Substance Abuse Services, effective July 1, 2003, and other applicable federal and state laws, rules and regulations, Vaya Health Plan members and recipients have the following rights:

- To be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation, or gender identity and to be free from any form of discrimination prohibited by federal or state laws, rules, and regulations
- To be told where, when, and how to get the services they need from Vaya
- To be told by treating providers what is wrong, what can be done and what will likely be the result, in language they can understand
- To be informed in advance of the benefits or risks of treatment choices and to a second opinion, at no cost to them
- To give approval of any treatment or plan for care after that plan has been fully explained to them
- To refuse care, except in a medical emergency or an involuntary commitment, and be told about risks of refusing care
- To get a copy of their medical record and talk about it with their PCP, and to ask, if needed, that their medical record be amended or corrected
- To confidentiality and to be sure that their medical record is private and will not be shared with anyone except as required by law, contract or with their approval
- To use the Vaya grievance or complaint process to settle complaints. Medicaid members may also contact the Medicaid Managed Care Ombudsman Program any time they feel they were not fairly treated.
- To appoint someone they trust (relative, friend or lawyer) to speak for them if they are unable to speak for themselves about their care and treatment

- To receive considerate and respectful care that respects their dignity in a clean and safe environment free of unnecessary restraints
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To receive information in accordance with federal Medicaid requirements (for Medicaid members)
- To humane care and freedom from mental and physical abuse, neglect, and exploitation
- To live as normally as possible while receiving care and treatment
- To be free from unwarranted searches of their person or seizure of their possessions
- To be free from unnecessary or excessive medication, which shall not be used for punishment, discipline, or staff convenience, and which shall be administered in accordance with accepted medical standards and only upon the order of a physician or other medical practitioner, as documented in their health record
- For members and recipients who live in adult care homes, to report any suspected violation of their rights to the appropriate regulatory authority as outlined in N.C.G.S. § 131D-21
- To freedom of speech and freedom of religious expression
- To exercise the same civil rights most natural, age-appropriate, and least restrictive environment possible
- To exercise the same rights as any other citizen, including the right to vote, marry, divorce, make a will and buy, sell and own property, unless they have been adjudicated incompetent
- To be free from the threat of unwarranted suspension or expulsion from treatment
- To participate in the development and periodic review of their written person-centered treatment or habilitation plan that builds on individual needs, strengths, and preferences
- To have an individualized treatment or habilitation plan implemented within 30 days of admission to any inpatient or residential facility
- The right to ask questions of Vaya or their treating providers at any point in the process and receive accurate information
- To participate in a candid discussion with their treatment providers about medically necessary treatment options and alternatives for the relevant diagnosis or condition, regardless of benefit coverage limitation
- To receive information on available treatment options and alternatives, presented in an appropriate way that they can understand
- To decide among relevant treatment options and express preferences about future treatment decisions, regardless of benefit coverage limitation
- To be informed of the cost of services at the first visit or during scheduling of the first appointment
- To receive written notification from Vaya about adverse decisions on requests for prior authorization
- To file an appeal with Vaya of the denial, reduction, suspension, or termination of a service and to request a State Fair Hearing (for Medicaid members) or appeal to the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (for state-funded recipients) if they disagree with Vaya's final decision
- To receive interpretation or translation services and other accommodations needed for accessibility, free of charge
- To a current listing of network providers and access to a choice of providers from within the network, to the extent possible or required by law
- To receive information about Vaya, our providers and member and recipient rights and responsibilities presented in a manner appropriate to their ability to understand

- To recommend changes to Vaya's policies and services. If they wish to do so, members and recipients should call the Member and Recipient Service Line at 1-800-849-6127 or write us at: Vaya Health, 200 Ridgefield Court, Asheville, NC 28806.
- To receive a written notice from Vaya of any "significant change" at least 30 days before the intended effective date of the change (for Medicaid members). This is a change that requires modifications to the N.C. State Plan for Medical Assistance, the Waiver or Vaya's contract with NC Medicaid.
- To make instructions for mental health, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI) treatment in advance to use if they become incapable of making such decisions. The forms used to do this are called advance directives.

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

Member and recipient rights can only be restricted for reasons related to care or treatment by their treatment team. A restriction of these rights must go through a Human Rights Committee for approval. Any restriction must be documented and maintained in the member's or recipient's medical record.

Rights of Individuals in 24-Hour Facilities

Members and recipients admitted to or living in a 24-hour licensed facility, including but not limited to Mental Health or I/DD Group Homes, Adult Care Homes, Psychiatric Hospitals and State-Operated Healthcare Facilities, have the rights listed above and have the right to:

- Receive necessary medical care if they are sick. If their insurance does not cover the cost, they will be responsible for payment.
- Receive a reasonable response to requests made to facility administration or staff
- Receive upon admission and during the stay a written statement of the services provided by the facility and the charges for these services.
- Be notified when the facility is issued a provisional (temporary) license or notice of revocation (reversal) of license by NCDHHS and the basis on which the provisional license or notice of revocation of license was issued. The responsible family member or guardian shall also be notified.
- Send and receive unopened mail and have access to writing material, postage and staff assistance if requested
- Contact and consult with an advocate
- Contact and see a lawyer, their own doctor, or other private professionals, at their own expense and at no cost to the facility
- Contact and consult with their parent or legal guardian at any time if they are under 18 years of age
- Make and receive confidential telephone calls, at their own expense and at no cost to the facility
- Receive visitors between the hours of 8 a.m. and 9 p.m. Visiting hours must be available for at least six hours each day, two hours of which must be after 6 p.m. If the member or recipient is under age 18, visitors cannot interfere with school or treatment.
- Communicate and meet with individuals that want to communicate and meet with them. This may be under supervision if their treatment team believes it is necessary.
- Make visits outside the facility unless their person-centered plan indicates that this is not recommended or the member or recipient was committed to the facility while under order of commitment to a DPS correctional facility OR as the result of the member or recipient being charged with a violent crime, including

a crime involving an assault with a deadly weapon, and found not guilty by reason of insanity or incapable of proceeding

- Be outside daily and have access to facilities and equipment for physical exercise several times a week
- Keep personal possessions and clothing, except those items that are prohibited by law
- Keep and spend a reasonable sum of their own money. If the facility is holding money for the member or recipient, they can examine the account at any time.
- Participate in religious worship if they choose
- Retain a driver's license, unless they are not of age or otherwise prohibited by law
- Not be transferred or discharged from a facility except for medical reasons, their welfare or another's welfare, nonpayment or if mandated by state or federal law. Members and recipients must be given 30 days' notice except in cases of safety to themselves or others. They can appeal a transfer or discharge (according to rules by the Medical Care Commission) and can stay in the facility until resolution of the appeal.

North Carolina's Adult Care Home Bill of Rights also outlines the rights of individuals residing in an ACH to include an individual's right to associate and communicate privately and without restriction with people and groups of his or her own choice.

Anyone receiving services in a licensed facility has the right to express a concern or grievance without fear of retribution. Concerns or grievances may also be brought forward by a guardian or anyone else authorized to speak on behalf of the person who is receiving services. NCDHHS Long-Term Care Ombudsmen serve as advocates for individuals living in ACHs throughout North Carolina. In addition, the N.C. Division of Health Service Regulation (DHSR) monitors complaints regarding licensed facilities.

Individuals living in State-Operated Healthcare Facilities are afforded all state and federal civil rights, including rights under: Article 3 of N.C.G.S. Chapter 122C, the Individuals with Disabilities Education Act (IDEA), The Americans with Disabilities Act (ADA), The Rehabilitation Act, the Civil Rights of Institutionalized Persons Act (CRIPA), and Title VI of the Civil Rights Act. Consumer Advocates are located in each State-Operated Healthcare Facility and are available to individuals and their families 24 hours a day, 7 days a week. Each State-Operated Healthcare Facility also has a Human Rights Committee that is appointed by the NCDHHS Secretary. These committees work to protect the rights of the people being served by the Facility. The Consumer Advocates are available to follow-up on any matters that are of concern to the Human Rights Committees.

Non-Discouragement

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

Informed Consent and Advocacy

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

- Advocate for medically necessary care or treatment options.
- Provide information the individuals need to decide among all relevant treatment options.
- Encourage the individual to participate in decisions regarding their health care and to express preferences about future treatment decisions through advance directives and crisis plans.

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

Right to Privacy and Security

Vaya Network Providers must ensure the confidentiality, privacy and security of all member and recipient health records in accordance with the Health Insurance Portability and Accountability Act of 1996, the HIPAA Privacy Rule, HIPAA Security Rule, 42 C.F.R. Part 2, N.C.G.S. 122C, Article 3 and other federal and state laws, rules, and regulations. You must also ensure that all employees and contractors maintain the confidentiality of persons receiving services and other information received while providing services.

This means that Network Providers and their employees and contractors must not discuss, transmit or narrate in any form any member or recipient information of a personal nature, medical or otherwise, except as authorized in writing by the member/recipient/Legally Responsible Person (LRP), or as permitted by applicable federal and state confidentiality laws, rules, and regulations. It is your responsibility to know what information can be disclosed, to whom and under what circumstances.

All electronic communications to or from members and recipients, or that contains protected health or other sensitive information, must be sent via a secure electronic mail system such as Zixmail. Please be aware that the HIPAA Privacy Rule requires all health care providers to develop and distribute a Notice of Privacy Practices that provides a clear, user-friendly explanation of individuals' rights with respect to their health information and the privacy practices of the health care provider.

More information and model notices are available at http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html. We may ask to see a copy of your notice at an on-site review. Vaya's Notice of Privacy Practices is available on our website.

Rights of Minors

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

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

24-Hour Facilities

Network Providers who operate 24-hour treatment facilities must provide the member with a document that explains the specific rules for that facility, including rules that cover hygiene, grooming, living environment, personal funds and storage and protection of clothing and possessions. Vaya 24-hour facility providers must explain and provide a copy of these rules to individuals within 72 hours of admission. Please refer to Subchapter 27F of the 10A North Carolina Administrative Code, Section .0100 through .0105 for more information about this requirement.

Guardianship

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

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

- N.C.G.S. § 35A-1201(5) states that "Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him." This is the public policy of North Carolina. This means that you must do your best to ensure that persons you are serving who are adjudicated incompetent are included to the fullest extent possible in treatment team meetings and other venues where decisions about his or her care are made.
- N.C.G.S. § 35A-1213(g) states that an employee of a treatment facility may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works. This means that employees of psychiatric residential treatment facilities, group homes, Alternative Family Living homes, Family Care Homes,

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

- N.C.G.S. § 35A-1213(f) states that an individual who contracts with, or is employed by an entity that contracts with, an LME/MCO for the delivery of behavioral health and I/DD services may not serve as a guardian for a ward for whom the individual or entity is providing these services. **In general, this means that Vaya Network Providers cannot serve as guardians for Vaya Health Plan members being served by the provider, practitioner, or staff member.** There are some limited exceptions:
    - A member of the ward's immediate family (meaning a spouse, child, sibling, parent, grandparent, or grandchild) who contracts with Vaya or works for a provider agency can still serve as guardian; or
    - A licensed family foster care provider or a licensed therapeutic foster care provider who was appointed to serve as a guardian on or before January 1, 2013; or
    - A biologically unrelated individual who was appointed to serve without compensation as a guardian on or before March 1, 2013.

Firearms and Concealed Carry Permits

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

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

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

Restrictive Intervention

Vaya prohibits the use of restrictive interventions by Network Providers except as specifically permitted by each member's person-centered plan or care plan, as applicable, or on an emergency basis. "Prone" restraints or any techniques whereby the restrained individual will end up in a face-down position are entirely prohibited. If a restrictive intervention is used three or more times within a 30-day period or is used as a therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures, it must be included in the member's person-centered plan or care plan, as applicable, as a planned restrictive intervention. Otherwise, it must be reported to Vaya's

HRC and/or in the state's Incident Response Improvement System (IRIS), as applicable. All restrictive interventions or devices utilized must comply with Article 3 of N.C.G.S Chapter 122C.

Client Rights Committee

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

Advance Directives

Advance directives (AD) are legal forms that allow individuals to make decisions about end-of-life care and plan ahead for their health treatment, including psychiatric and physical health treatment. Vaya complies with all state and federal laws and regulations related to advance directives, including Article 23 of Chapter 90 of the General Statutes, 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.

The State of North Carolina has specific forms that can be used for individuals to create advanced directives. NCDDHS maintains the forms, as well as resource documents to help members understand advance directives, at https://www.sosnc.gov/forms/by_title/_advance_healthcare_directives. Vaya supports the use of "Health Care Power of Attorney", "Advance Directive for a Natural Death: Living Will", "Advance Directive for Mental Health, and "Advance Directive – Expanded". These advance directives enable individuals to plan ahead for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will.

You are responsible for educating members about the ability to create advance directives and assisting members who express the desire to create one. If you are assisting a member in completing an AD, plan on several meetings to thoroughly think about crisis symptoms, medications, facility preferences, emergency contacts and preferences for staff interactions, visitation permission and other instructions.

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

The Vaya Member and Recipient Handbook includes more information about ADs and related resources.

SECTION 16 | Member and Recipient Cost-Sharing Requirements

Some Medicaid members may be required to pay a copay for certain physical health care services or prescriptions:

Copays for Medicaid Beneficiaries*	
Service	**Member Copay**
Physicians Outpatient services Podiatrists	$4 per visit
Generic and brand prescriptions	$4 per script
Chiropractic Optical services/supplies	$4 per visit
Optometrists Non-emergency visits to the emergency department	$4 per visit

***There are NO copays for the following people or services:**

- Members under age 21
- Services related to pregnancy, childbirth and postpartum care – to include prenatal care
- Members receiving hospice care
- Federally recognized tribal members or members receiving services through Indian Health Services (HIS)
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- Children in foster care
- People living in an institution who are receiving coverage for cost of care
- Behavioral health services
- Intellectual/developmental disability (I/DD) services
- Members enrolled in 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 Long Term Support Services (LTSS)
- Family Planning Services
- Services covered by Medicare and Medicaid

A provider cannot refuse to provide covered physical health care services authorized by Vaya if a Medicaid beneficiary cannot pay.

Please note that Vaya recipients do not have to make any payment or co-pay for State-funded Services that Vaya has approved for the recipient.

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SECTION 17 | Provider Program Integrity Requirements

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

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

- **Billing for services not provided:** A provider bills for services or items never rendered or furnished.
- **Medical identity theft:** A provider uses stolen identity to bill for services not provided, including the billing of services allegedly rendered to someone who was discharged from care or is deceased.
- **Billing for unnecessary services or tests:** A provider falsifies the diagnosis and symptoms on patient records and billings to obtain payments for unnecessary services, laboratory tests or equipment.
- **Billing for services that lack documentation:** A provider bills for services for which the provider knows that required documentation is absent or inadequate.
- **Double billing:** A provider bills both Medicaid and a private insurance company (or member) for the same treatment, or two providers request payment on the same member for the same procedure on the same date.
- **Upcoding:** A provider bills at a level of complexity that is higher than the service actually provided or documented. For example, billing for 60-minute therapy sessions when you only spend five minutes or fewer with the member.
- **Unbundling:** A provider bills for services separately (using multiple procedure codes) rather than using the fixed daily “bundled” rate or single comprehensive code.
- **Billing for unreasonable or inflated hours:** A provider inflates the amount of time a spent with patients (for example, a psychiatrist who bills for more than 24 hours of psychotherapy treatment on a day).

- **Falsifying credentials:** A provider misrepresents the license or credentials of a practitioner in order to bill Medicaid.
- **Substitution of generic drugs:** A pharmacy knowingly bills Medicaid for the cost of a brand-name prescription when, in fact, a generic substitute was supplied to the member at a substantially lower cost to the pharmacy.
- **Billing for more expensive procedures than were performed:** A provider bills for a comprehensive procedure when only a limited one was administered or bills for expensive equipment and actually furnishes cheap substitutes.
- **Kickback:** A hospital requires another provider, such as a laboratory or ambulance company, to pay a certain portion of the money received for rendering services to patients in the facility.; or a provider induces Medicaid beneficiaries to enroll with the provider or request services in exchange for gifts or payments. Examples include gift cards, vacation trips, personal services and merchandise, leased vehicles and direct payments.
- **False cost reports:** A provider includes personal expenses in Medicaid cost reports. These expenses often include the cost of personal items.

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

Fraud

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

Waste

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

Abuse

Abuse is defined as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program" (42 CFR Part § 455.2). Abuse is also defined at

10A NCAC 22F .0301 to include "any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary including, for example, the following:

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

For more information, please refer to the following helpful Fraud, Waste and Abuse Toolkit for providers, created by CMS and available at: https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html.

How to Report Suspected Fraud

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

- Call the Vaya Confidential Compliance (Fraud and Abuse) Hotline at 1-866-916-4255 (24 hours a day, seven days a week, allows for anonymous reporting). Reports may also be made by calling any Vaya office number and asking for the Compliance Officer.
- Report online at vayahealth.ethicspoint.com (allows for anonymous reporting).
- Call the N.C. Medicaid Fraud, Waste and Program Abuse Tip-Line at 1-877-DMA-TIP1 (1-877-362-8471).
- Call the U.S. Office of Inspector General's Hotline (to report fraud) at 1-800-HHS-TIPS (1-800-447-8477).

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

Compliance with Other State and Federal Requirements

FALSE CLAIMS ACT

The Social Security Act, as amended by the Deficit Reduction Act of 2005, requires that Vaya establish an education plan for our employees, managers, contractors and agents about state and federal false claims laws and whistleblower protections. 42 U.S.C. § 1396a(a)(68). We offer this education to our providers via this Manual,

Provider Bulletins and training opportunities. If you receive more than $5 million in Medicaid funds annually, you are also required to establish and implement an education plan for your employees, managers, contractors and agents that includes written policies and detailed guidance on the federal False Claims Act, state false claims laws and the rights and protections afforded whistleblowers under the FCA and its state counterparts.

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

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

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

The civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or former employees, patients or competitors.

Network Providers must publicize Vaya's Compliance Hotline (1-866-916-4255) for staff and members to report potential fraud, waste, or abuse. Provider employees are strongly encouraged to report any instance of anything they think might constitute potential fraud, waste, or abuse occurring at Vaya or by a Network Provide involving services reimbursed by Vaya. We offer a robust internal reporting process and evaluate all referrals and concerns that are reported. Each Network Provider must conduct self-audits and report any instances of fraud, waste or abuse discovered.

The Special Investigations Unit (SIU)

Vaya's Special Investigation Unit (SIU) is tasked with investigating allegations of fraud, waste, or abuse. The SIU also conducts data mining and data analytics and systematically monitors paid claims to look for trends and patterns suggestive of fraud, waste or abuse. If we determine that a complaint, allegation or trend rises to potential fraud, we must forward the information and any evidence collected to DHB, who will make a determination whether the allegation is credible and whether to make a referral to the Medicaid Investigations Division (MID) of the N.C. Attorney General's Office. If we determine there is no potential fraud, but that waste or

abuse is present, we will continue with our investigation. In making these determinations, we use the federal and state definitions and guidance described previously in this section.

The SIU may conduct their investigations as a desk review. The investigation may also include an announced or unannounced site visit at the provider's office. The first step in most investigations is to request records documenting service delivery. If you receive a request for records from the SIU, you must respond within the timeframe stated in the letter. The letter will also include a contact number for you to reach the investigator assigned to the case. If the review of records from the initial request indicates a high percentage of out-of-compliance findings or reveals other concerns or potential waste or abuse, we may issue another records request to expand the scope of the review. Please call us if you have any questions about the records request or investigation process. If you do not return records as requested, we may determine that all claims reimbursed for the dates of service and individuals under review constitute an overpayment.

The SIU will review the records and determine if any overpayment is due, which primarily includes a determination of whether the documentation submitted complies with requirements and supports the billing of services. We employ licensed practitioners on staff who may also review claims against medical necessity requirements. As stated in section 3 of this Manual, authorization is not a guarantee of payment. If the SIU determines that medical necessity was not present at the time-of-service delivery based on the documentation you provide, we may identify an overpayment. Vaya's Finance Department and certified accountants can also assist SIU with the review of compliance with coordination of benefits requirements, financial reports, financial statements and adherence to Generally Accepted Accounting Principles.

There are times when a SIU investigation referral identifies areas of potential waste or abuse of Medicaid or Non-Medicaid funds that may be corrected by a Vaya initiated provider self-audit. A cooperative effort serves a common interest of protecting the financial integrity of the Medicaid Program while ensuring proper payments to providers. Any overpayments a provider identifies during a Vaya initiated self-audit are not subject to reconsideration. Should a provider choose not to participate in a Vaya initiated self-audit an investigation may be initiated by SIU. At any point during a Vaya initiated self-audit, SIU may determine that an investigation is warranted.

Recovery Audit Contractors (RACs) for the Medicaid program may also audit providers in our Closed Network and may work collaboratively with Vaya on identification of overpayments. DHB shall require RACs to give Vaya prior written notice of such audits and the results of any audits as permitted by law.

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

The SIU may utilize the prepayment pending of claims while an investigation of billing anomalies is investigated or as a corrective action measure. In advance of prepayment, Vaya's Regulatory Compliance Committee (RCC) must approve prepayment review and the provider must be notified in writing (Prepayment Review Notification Letter).

The process automatically pends the provider's claims so that a clinical medical record review can ensure the provider's documentation supports the claim's billed prior to payment. Claims received without medical records will be denied and the provider will be instructed to resubmit the claim with records. Upon completion of the prepayment review, the claim is processed according to the clinical review recommendations. A monthly prepayment pended claim review status letter will be sent to the provider including a description of the findings of completed reviews. The SIU Investigator will monitor the provider's billing accuracy while the provider is on prepayment review. When a Provider's billing accuracy falls into compliance (as defined in the Prepayment Review Notification Letter) for a minimum of one quarter, SIU management may remove the provider from prepayment review with the approval of RCC. For Providers that are noncompliant with the prepayment review, further actions may be taken, up to and including contract termination.

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SECTION 18 |
Medicaid Providers

Medicaid Provider Ombudsman Service

As part of Medicaid Transformation, NC Medicaid created a Provider Ombudsman Service to represent the interests of the provider community by receiving and responding to inquiries and complaints regarding health plans. The ombudsman offers resources and helps providers resolve issues. Additionally, the ombudsman assists providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

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

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SECTION 19 | Prevention and Population Health Programs

Introduction

Vaya Health ("Vaya") takes a population-based approach to improving the overall health of Medicaid members and works collaboratively 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 identified in Community Health Assessments conducted by our service area's Local Health Departments (LHDs). Vaya makes these programs available to all members, using multiple sources and pathways to identify members who are likely to benefit.

Alignment with Department Priorities

Vaya's prevention and population health programs align with the Department's larger public health goals and Quality Strategy. Department-identified priorities include the following:

- Diabetes prevention and management,
- Asthma,
- Obesity,
- Hypertension,
- Tobacco cessation,
- Infant mortality,
- Low birth weight,
- Early childhood health and development, and
- Additional prevention and population health management programs to encourage improved health and wellness among members, such as interventions that will improve functional status and quality of life among members with behavioral health issues, intellectual and/or development disabilities (I/DD) or traumatic brain injury (TBI).

Promoting Wellness and Prevention

Vaya's plan-based Tailored Care Managers will promote wellness and prevention by educating members about and referring them to Vaya's prevention and population health programs and/or other programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation and self-help recovery, and other wellness services based on the member's

needs and preferences. Network Providers are encouraged to participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, e-cigarettes, and other drugs) by members and to improve the emotional health and well-being of members.

Vaya notifies Tailored Care Management providers when one of their members is participating in a prevention and population health program. Vaya sends these notifications through the Provider Portal but may also send them via fax or mail if needed.

DIABETES PREVENTION INTERVENTIONS

Vaya's goal in diabetes prevention is to decrease the percentage of our population who develop diabetes. Network Providers play a key role in this effort by screening members and linking them to effective lifestyle change programs that have the best chance to promote normal blood sugar levels. Vaya's members are in highly vulnerable populations that have increased risk for diabetes. Populations affected include those diagnosed with severe mental illness (SMI), intellectual and developmental disabilities (I/DD) and substance use (SU). Lack of screening at appropriate intervals is a health disparity for Vaya's members which needs special attention.

North Carolina has more than 75 Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Program (DPP) providers that offer online or onsite classes. Diabetes Prevention Programs are provided in varied community locations in our service area, including local health departments (LHDs), YMCAs, community centers, faith-based organizations, hospitals, and worksites. The programs are evidence-based, positive lifestyle change programs for members at risk of developing diabetes. Programs encourage eating healthier, reducing stress, and increasing physical activity.

Network Providers should identify members who are in the at-risk population and offer linkage to screenings and to DPP programs. Network Providers are required to conduct screenings or ensure members have been screened for abnormal blood glucose levels in people taking an antipsychotic, are overweight or have obesity. These screenings occur, at a minimum, on a yearly basis in people who continue to have normal blood glucose. Monitoring should be continued if the member's blood glucose is elevated.

Network Providers of historically marginalized populations should understand the increased risk of diabetes in historically marginalized populations. Member engagement and education play a significant role in our diabetes prevention campaign. To align with Vaya's efforts, Network Providers should use evidence based educational materials to coach members on the role of low activity levels on metabolic diseases, the impact of a family history of diabetes, and the role of obesity and impact of smoking on blood sugar levels.

Member Education and Program Referrals

Our population health programs include procedures for referral and education to increase access to resources that support members' health goals. Network Providers may direct members to our website to take self-administered screenings and/or use our Prevention and Population Health Programs referral form. Network Providers may also contact Vaya's Member and Recipient Services department to refer members to a prevention and population health program. Network Providers should work collaboratively with Vaya to implement targeted health initiatives and promote wellness and prevention initiatives to members and recipients. Network Providers should refer members to existing resources in the community, including YMCA programs that promote exercise,

the Western North Carolina Aids Project and the North Carolina AIDS Action Network, which provides clean injection supplies. Focus areas for member education and program referrals include the following: exercise, nutrition, stress management, tobacco cessation, harm reduction and relapse prevention and suicide prevention.

Ensuring Appropriate HIV and Hepatitis C Screenings

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENINGS

An estimated 1.1 million people in the United States have the human immunodeficiency virus (HIV), and approximately one in seven (nearly 15%) are unaware of their status. About 40% of new HIV infections are transmitted by people undiagnosed and unaware they have HIV.

Diagnosing HIV quickly and linking people to treatment immediately are crucial to achieving further reduction in new HIV infections. Primary care providers (PCPs) are the front line for detecting and preventing the spread of HIV. In alignment with the Centers for Disease Control and Prevention (CDC) Vaya requires PCPs to:

- Conduct routine HIV screening at least once for all their patients
- Conduct more frequent screenings for patients at greater risk for HIV
- Link all patients who test positive for HIV to medical treatment, care, and prevention services

Primary care providers are expected to be familiar with and follow the CDC's Guidelines related to HIV screening.

HEPATITIS C VIRUS (HCV)

Routine HCV screenings and education at behavioral health visits improves chronic hepatitis C management interventions. The CDC recommends one-time hepatitis C testing of all adults (18 years and older) and all pregnant women during every pregnancy. The CDC continues to recommend people with risk factors, including people who inject drugs, be tested regularly. Therefore, Network Providers are required to screen for Hepatitis C or confirm that the recommended screening has been completed and include harm reduction and treatment as prevention. Primary care providers are expected to be familiar with the CDC's Hepatitis C Guidelines and follow them. Vaya will coordinate with local Ryan White HIV case management programs and providers.

Promoting Child Health and Wellness

Monitoring the health of children and early health interventions are key to promoting long-lasting health in those who live in our communities.

PREGNANCY INTENDEDNESS

Unplanned pregnancies come with higher risks, such as unmanaged chronic conditions, genetic or behavioral risks, or unhealthy prenatal behaviors such as smoking or alcohol use. To align with Vaya's prevention program, primary care providers and Tailored Care Managers should encourage members and families to talk with their providers about reproductive health, contraception options, and family planning.

INFANT MORTALITY AND BIRTH OUTCOMES

Vaya's strategies to reduce preterm births include promoting adequate birth spacing, providing education around positive preconception behaviors, helping women quit smoking, and providing high-quality medical care for

women during pregnancy. Network Providers should conduct a domestic violence screening at prenatal and postpartum visits, offer diabetes screening during the first trimester with appropriate follow up and offer depression screening at postpartum visits. To aid members who screen positive on domestic violence and depression screenings, Network Providers may refer members to resources through utilization of the NCCARE360 platform, Vaya's website or by contacting Vaya's Call Center.

EARLY CHILDHOOD PRIORITIES

Vaya's program priorities align with the vision of the NC Early Childhood Action Plan which states that all children will get a healthy start and develop to their full potential in safe and nurturing families, schools, and communities.

On a member level, we use a comprehensive outreach and education strategy around Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) well-visits and screenings that include text message campaigns for screening and immunization reminders. We outreach members if an EPSDT gap is identified, link members to toddler and infant programs in the community and provide assistance with scheduling transportation or appointments. Vaya and Network Providers should link children and their families to recommended preventive health services at an early age, including access to oral health care. Additionally, Vaya, with the assistance of its Provider Network, attempts to administer the Care Needs Screening to all members to identify and address unmet health-related resource needs (e.g., food insecurity, housing insecurity, exposure to interpersonal violence/toxic stress/domestic violence and transportation needs).

We offer training for Network Providers about the Vaccines for Children (VFC) program and the North Carolina Immunization Registry. We also train Network Providers about EPSDT review requirements for utilization management and notify them of members who may have missed appointments. We promote screenings and prevention with school districts and community centers, and support health education events and forums to promote early childhood intervention.

WOMEN, INFANTS, AND CHILDREN PROGRAM (WIC)

Vaya expects Tailored Care Management providers to identify members potentially eligible for WIC, makes referrals, and provide comprehensive application assistance to help members access the WIC program as needed. Members potentially eligible for the WIC program include pregnant women, women up to six months postpartum, breastfeeding women up to one year postpartum, and infants/children under age five. Linkage to the preexisting WIC programs may occur through the Vaya website with linkage directly to the WIC Special Supplemental Nutrition Programs allowing members and care managers the ability to easily locate the WIC program in the desired county.

NEWBORN SCREENING

Newborn Metabolic Screening Services detect selected metabolic and genetic conditions at birth. All infants born in North Carolina should be screened at birth for the following conditions:

1. Congenital hypothyroidism (CH),
2. Galactosemia,
3. Congenital adrenal hyperplasia (CAH),
4. Hemoglobinopathy disease (e.g., sickle cell),
5. Biotinidase deficiency,
6. Cystic fibrosis,

7. Severe combined Immunodeficiency (SCID), and
8. Certain metabolic disorders detectable by "Tandem Mass Spectrometry" (TMS), including phenylketonuria (PKU).

Consistent with NC Gen. Stat. §§ 130A-125 and 130A-130.2, Vaya's Network Providers must comply with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-up Program and ensure that all lab testing for samples drawn for newborn screening under this statute are sent to the NC State Lab for processing.

Vaya coordinates with NCDHHS on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula for Medicaid members.

NEWBORN HEARING SCREENING

Vaya promotes awareness of NC's Early Hearing Detection and Intervention (EHDI) Program. This program aids and provides education to hospitals, medical providers, and others. By connecting families to available resources, it supports families and helps them get the care their baby needs.

Consistent with NC Gen. Stat. § 130A-125 and 10A NCAC 43F, Network Providers must comply with state law and regulatory requirements governing the Newborn Hearing Screening Program, including reporting to the Early Hearing Detection and Intervention (EHDI) Program. Vaya establishes a joint plan with NCDHHS to implement the requirements of hearing screening by one month of age, diagnostic evaluation by three months of age, and intervention by six months of age during Contract Year 1 or a time period otherwise defined by NCDHHS.

VACCINES FOR CHILDREN (VFC) PROGRAM AND NC IMMUNIZATION REGISTRY

Vaya recognizes the critical role that vaccination plays in individual- and population-level health outcomes. Our vaccination initiative targets our infant and child member population. The CDC-recommended schedule of pediatric immunizations guides our strategy. Vaya sends vaccine education and reminders to our membership. Our member-facing website includes information on the importance and benefits of vaccinations, including COVID-19 vaccinations. Through partnership with Network Providers and local health departments, we identify reasons for vaccine hesitancy, whether they are barriers to receiving the vaccine or beliefs that have a protected exemption under North Carolina law. We obtain member feedback from Consumer and Family Advisory Committee (CFAC) and Innovations Stakeholders. Based on information that we gather from our members, we use communication strategies, venues, and language that incorporate cultural humility and compassion to address vaccine hesitancy. We also review immunization status during care transitions and include immunization screenings and education throughout enrollment processes, wellness programs, and disease management programs. Through our annual Learning Summits, provider meetings, provider communications, provider-facing website, and provider trainings, Vaya delivers general vaccine education, including VFC program linkage, use of the NC Immunization Registry and You Call the Shots training. Network Providers should partner with Vaya to reduce false or misleading information about vaccine effectiveness and help provide vaccine science resources that Network Providers can distribute. Network Providers may access the NC Department of Public Health Immunization Branch for enrollment requests and additional information.

Promoting Women's Health

North Carolina Women's Health Report Card uses many different data sources to provide an accurate picture of women's health and Vaya uses this information to focus our efforts in the most impactable areas. The topics of

women's health most needing attention include preventive health, prenatal health, chronic disease, obesity, mental health and substance use disorder, cancer, infectious disease, poverty, and access to healthcare. Primary care and/or obstetrics/gynecologists (OB/GYN) providers are expected to conduct cervical cancer screenings on women ages 21-64 who had cervical cytology performed every three years and women ages 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years. Primary care and/or OB/GYN providers are also expected to conduct Chlamydia screenings in women ages 16-24 who are identified as sexually active. Primary care and OB/GYN providers are expected to engage pregnant members in prenatal care visits within the first trimester and postpartum visits between seven and 84 days after delivery.

Improving Chronic Condition Management

Interventions that impact chronic conditions in our population have the potential to yield the most results for overall population health. Vaya's Chronic Condition Management programs address Behavioral Health, Diabetes, Hypertension and Asthma in alignment with NCDHHS.

Vaya has designed clinically sound interventions to achieve Program goals but recognizes that provider-based Tailored Care Management entities also may have developed successful programs that achieve the same outcomes. We do not mandate that provider-based Tailored Care Managers use the exact interventions described herein. Instead, we expect Tailored Care Management providers to achieve the same goals through any effective interventions they choose. Vaya offers support to Network Providers who do not have these programs in place to enable them to build an effective program as part of the Tailored Care Management service.

BEHAVIORAL HEALTH CARE

We aim to continue our proven history of meeting or exceeding NCDHHS standards for quality and performance measures and routinely demonstrate our excellence in developing unique solutions and strategies for complying with these measures. Vaya generates a monthly report based on Medicaid paid claims data from the previous 90 days. Our Network Providers demonstrated an 11.6% increase in follow-up after discharge in fiscal year 2020. The ED admissions metric measures the rate per 1,000 members using the ED who are in active treatment with a provider during the measurement period. Vaya reviews this measure with our Network Providers in regular meetings and works with Network Providers to develop interventions to reduce the ED admit rate. Our Vice President of Physical Health and Value Based Care works with Vaya's Quality Management Team and Network Provider quality staff to develop quality improvement projects for this and other measures. Providers are required to participate in quality improvement projects. Other measures that we track include use of multiple anti-psychotics in adolescents and children, metabolic testing for children and adolescents on antipsychotics and antidepressant medication management.

DIABETES MANAGEMENT

Vaya is committed to a team-based approach to diabetes management and believes collaboration between clinical staff, care managers, and members improves the health and quality of life for members. Provider-based Tailored Care Managers should encourage members to follow preventive service recommendations made by their providers (e.g., to get a foot exam, flu and pneumonia vaccines, a dental exam, or a retinal eye exam) and clinical guidelines (e.g., checking A1C, blood pressure, and cholesterol levels) and assist members when needed to attend schedule appointments for these services and train members on use of self-monitoring tools.

Asthma, hypertension, nicotine dependance, cardiovascular disease, hyperlipidemia and depression are significant and common comorbidities with type 2 diabetes. These comorbidities make diabetes a challenging disease to manage. Tailored Care Managers should consider the member's learning style, cognitive abilities, social and economic factors, and physical limitations in interactions with our members. Tailored Care Managers should identify and address barriers to care which may include transportation, lack of education about diabetes, or behavioral health symptoms. Tailored Care managers should link members to self-management support to increase the chances of remaining healthy while living with type 2 diabetes.

Vaya requires Network Providers to monitor all members diagnosed with diabetes and communicate to the member or their caregiver the need for further/timely monitoring of the following items:

- Hemoglobin A1C
- Lipid panel
- Medical attention for diabetic nephropathy (urine micro albumin, etc.)
- Diabetic retinal exam and
- Prescriptions necessary for: diabetes, lipid lowering agents, hypertension, and blood glucose monitoring.

It is important for Network Providers to refer members to or provide Diabetes Self-Management Education and Support (DSMES) services via their internal diabetes educators or our network of diabetes educators. For our providers who do not offer these DSMES, but are interested in doing so, we suggest using the DSMES toolkit.

ASTHMA MANAGEMENT

Vaya's Asthma Management Program helps members get their asthma under control and lead healthier lives. We aim to prevent long-term (chronic) symptoms that interfere with daily living and allow our members to participate in all activities of daily living at work, school, and recreation. Ultimately, our goal is to decrease asthma-related emergency department visits and hospitalizations for our population.

Asthma Self-Management Education (AS-ME) is a specific intervention that can improve asthma control and reduce health care costs. Tailored Care Managers should offer AS-ME for members whose asthma is not well controlled through medical management alone. Key educational messages of AS-ME include basic facts about asthma, roles of medications, how to use asthma medications correctly, what to do when asthma symptoms worsen, and how to reduce exposures to asthma triggers (e.g., environmental allergens and irritants).

Tailored Care Managers also help members work with you as the provider, to develop an asthma action plan to support your ability to effectively self-monitor. Use of these plans increases the chances that members can both prevent and control asthma attacks. Creating an asthma action plan and following it, even when there are no asthma symptoms, is important for long term asthma control. Learning personal triggers and avoiding them, when possible, will prevent members' asthma from getting worse.

When Vaya's pharmacy staff identifies opportunities to increase inhaler adherence, Vaya's nurses provide direct member/caregiver education to maximize access and effectiveness of this medical intervention.

Vaya promotes strategies that help people access and continue to use asthma medications and devices. We cover spacers as a medical device without a copay for children under 21 up to the annual limit to encourage spacer use

and improved inhaler administration. We encourage 90-day refills on asthma maintenance medications and monitor for rescue inhaler overuse.

Tobacco use and secondhand exposure is a trigger for asthma attacks. Interventions to reduce smoking and secondhand smoke exposure can improve asthma control and reduce health care costs. Vaya employs an array of interventions designed to assist members to stop smoking which includes access to Quit for Life. These are described in more detail in the Tobacco Cessation section.

Vaya aims to increase the use of effective interventions by linking Network Providers to asthma-focused training tools. Vaya also encourages the use of decision support tools that promote guidelines-based medical management. Examples include current asthma guideline summaries and treatment algorithms. We encourage you to use Electronic Health Record (EHR) system reminders to increase the likelihood of adherence to evidence-based recommendations.

Shared decision making has been shown to improve adherence to recommended asthma treatments, allowing for discussions of goals, preferences, and patient concerns. Using this readily available technique has been shown to decrease rescue medication use, improve lung functioning and result in fewer asthma-related medical visits. We include education on shared decision making in our provider education and trainings specifically as it relates to asthma action plans.

HYPERTENSION MANAGEMENT

Heart disease and stroke are the first and fifth leading causes of death in the United States. Controlling high blood pressure is an important step in preventing heart attacks, strokes, and kidney disease. Of the nearly 57 million U.S. adults who are taking blood pressure medicines, only half have their blood pressure under control.

Medication Therapy Management programs are an important part of hypertension management and have been shown to significantly increase blood pressure control. Vaya uses this program to improve blood pressure control. Vaya leverages retrospective pharmacy utilization review programs to help members use their antihypertensive medication as prescribed.

Vaya encourages collaboration between prescribers and dispensing pharmacies for improved blood pressure control. We educate Network Providers about methods to improve hypertension control. Methods include pharmacy interventions such as a 90-day supply of medications, combination medications, and blister packs. Tailored Care Managers support members so that they understand the importance of adhering to prescribed therapy, self-measured blood pressure monitoring, a 90-day supply of antihypertensive medication and quarterly Primary Care Provider (PCP) check-ins.

Tailored Care Managers should be committed to the team-based approach to address hypertension. Team-based care increases the proportion of people with controlled blood pressure and reduced systolic and diastolic blood pressure, especially when pharmacists and nurses are part of the team. Vaya's pharmacist identifies members who have hypertension during chart review and directs Vaya RN staff to initiate member education and prescriber contact if appropriate.

Vaya monitors members receiving plan-based Tailored Care Management with diagnoses of hypertension that are not prescribed blood pressure lowering medications and uses this information in our team-based approach to

identify barriers to care, provide education around lifestyle modifications and set goals which support members in improved health outcomes. For members receiving plan-based Tailored Care Management, or members who choose to enroll in our hypotension management program, Vaya uses targeted interventions including observing the member describe a routine that includes checking and logging blood pressure per physician recommendation over the last 30 days and sharing that log with the physician. When Vaya's Tailored Care Managers make home visits, they review members' medications and inquire about how closely the member follows their prescribers' recommendations for taking their medication. Tailored Care Management providers are encouraged to implement similar interventions.

Our plan-based Tailored Care Managers are trained to understand the impact of stress, socioeconomic status, anxiety, depression, and other health behaviors on coronary heart disease risk. Tailored Care Management staff must understand the importance of addressing the member's psychological factors in parallel with treatment for hypertension. Member engagement is tailored and person-centered, taking into consideration a member's hypertensive management with diabetes, ethnicity/race, and other health conditions (like chronic kidney conditions) due to their increased risk of poor outcomes.

Network Providers are encouraged to use Million Hearts Hypertension Control Change Package Second Edition which includes key foundations, equipping care teams, population health management, and individual support around hypertension control. These interventions include change concepts such as providing blood pressure checks without appointment or co-payment, flowcharts for how members with hypertension can be tracked and managed, the systematic use of evidence-based hypertension treatment protocols, and the use of direct care staff to facilitate member self-management.

Tobacco Cessation

For more information on Tobacco Cessation, see Vaya Health's Tobacco Cessation Plan. Tobacco use is the top preventable cause of death among individuals with behavioral health disorders. People with co-occurring behavioral health disorders and tobacco use disorder lose an average of 25 years of their lives due to tobacco use and represent half of the annual deaths from tobacco in the United States, despite representing only a quarter of the population. All Vaya members/recipients receive a Member Handbook or Recipient Handbook, each of which includes information on the health risks of tobacco use and where to find additional information that supports efforts to reduce or stop tobacco use. The Vaya website will also link to Quit for Life and other online resources that members, their families and community stakeholders may easily access at any time. Linking to Quit for Life allows users to engage in active planning for their health. It includes a feature called "Create My Quit Plan", a tool to develop tobacco cessation plans.

Network Providers are required to post signage at their offices informing patients and guests that provider campuses are tobacco-free and how to access the support of Quit for Life. Network Providers are also required to include information about tobacco cessation resources on their provider websites. Network Providers are required to assess members and recipients for tobacco use when administering a Comprehensive Clinical Assessment (CCA) or during annual physical exams (for members only). Network Providers are required to offer evidence-based tobacco screening and treatment. If a member is identified as a tobacco user, Network Providers must offer tobacco cessation counseling, as well as written educational materials on the health benefits of reducing tobacco use. Additionally, Network Providers are required to make these printed materials available in their office lobby and on their website for others to access.

Provider-based Tailored Care Managers must conduct tobacco screenings. Network Providers, including inpatient and facility-based service providers, must screen for tobacco use and provide tobacco cessation education and referrals as appropriate. Screenings may occur through Tailored Care Management comprehensive assessments, behavioral health Comprehensive Clinical Assessments (CCAs), inpatient admission assessments, facility-based intake assessments and/or annual primary care visits. Assessment should include first- and secondhand exposure to tobacco products. Responses to the assessments should trigger a more comprehensive nicotine and vaping questionnaire, which assesses for using cigarettes, cigars, smokeless tobacco, vaping and second- and third-hand smoke exposure. For child and adolescent members, screenings should include additional customized questions about vaping and other routes of tobacco use. Substance Abuse Block Grant and Prevention providers are expected to deliver local, community-based tobacco cessation education across the Vaya region.

Tobacco use/exposure needs identified in screenings and assessments are addressed in all care plans/ISPs as appropriate for the needs and preferences of each member and recipient. Depending on the use/exposure identified and the member's preference, Network Providers should implement various methods of education, coaching and referral. Vaya does not require prior authorization for tobacco cessation counseling.

TOBACCO CESSATION BEHAVIORAL HEALTH PROGRAM

Through Quit for Life, Vaya offers an intensive Tobacco Cessation Behavioral Health Program for members who use tobacco and have a behavioral health diagnosis. Among other benefits, this program includes a team of dedicated coaches with extensive training about mental illness and tobacco use treatment. Quit for Life coaches adjust interventions and tailor treatment to meet participant needs. This 12-week program includes nicotine replacement therapy in the form of nicotine patches, with nicotine gum or lozenges available as supplements to reduce cravings. Members can access the program using a link on our website. Quit for Life conducts eligibility screening for the program.

TOBACCO CESSATION PREGNANCY PROGRAM

Quitting tobacco during pregnancy and while living at home with young children has positive impacts on infants and children, including:

- Promoting healthier brain development
- Lowering risk of miscarriage, stillbirth, and Sudden Infant Death Syndrome (SIDS)
- Lowering risk of being born too small or too early
- Lowering risk of coughs, colds, and ear infections
- Lowering risk of asthma
- Lowering risk of cancer, diabetes, and heart disease in adulthood

Through Quit for Life, Vaya offers a special program for women planning or experiencing a pregnancy and new mothers who use tobacco products (including vaping). Members can access this program through the same webpage as our other tobacco cessation services. When a member calls Quit for Life, they are screened and paired with an expert "quit coach" trained to provide specific interventions for pregnant women. Members and recipients are also referred to the program "You Quit Two Quit", a guide to help new mothers stay tobacco-free.

Opioid Misuse and Prevention

The Opioid Misuse Prevention and Treatment Program is administered by Vaya, and it complements the Drug Utilization Review program. Vaya supports the safe use of opioid medications, based on current scientific research and clinical best practices. We support members and their caregivers in having a full understanding of the risks and benefits of opioid use. Opioid medications are very effective at managing acute pain for short periods of time. However, the risk of moving down the path of dependence and addiction increases when opioid use continues beyond five days.

Vaya aligns its clinical coverage policies with state and federal policies and guidelines for Office-Based Opioid Treatment (OBOT). Vaya also ensures the appropriate use of prescription opioid analgesics through prospective drug utilization review, prescription (days' supply) limits in accordance with the NC strengthen Opioid Misuse Prevention (STOP) Act, and prior authorization requirements in the Department's clinical coverage policy for opioid analgesics.

Through the Western North Carolina Substance Use Alliance, Vaya seeks to increase collaboration among agencies to target the opioid use epidemic. Providers are encouraged to expand Medication Assisted Treatment (MAT) and strengthen the continuum of treatment and prevention services available to children and adults. Network clinicians may access the CDC Guidelines for Prescribing Opioids for Chronic Pain through the Vaya provider portal. Providers are required, through the STOP ACT of 2017, to review member opioid utilization through the NC Controlled Substance Reporting System (NC CSRS). Vaya helps providers and pharmacies access the CSRS system through our provider services teams. Providers are encouraged to review up-to-date guidance from the NC Boards of Medicine and Pharmacy to align prescribing with state rules.

Person-centered treatment with opioid analgesic medication should include a treatment plan agreed upon by the member and their provider. Providers are required to educate members on their rights and responsibilities to ensure the safe use of opioids. Vaya encourages providers to develop and use treatment plan templates to help structure the safe use of opioid analgesics. Vaya works with prescribers and area laboratory testing facilities to ensure routine, appropriate use of drug testing for opioid treatment and controlled substances.

Network Providers must comply with the STOP Act's quantity limits, mandatory electronic prescribing, and utilization of the NC CSRS. To support the critical components of our pharmacy benefit programs, Network Providers are required to:

- Ensure initial opioid claims for acute injury are for no more than a five- or seven-day supply following surgery
- Check the NC CSRS and documenting results in the medical record at a frequency consistent with clinical best practices and NC law
- Request prior approval for members utilizing a cumulative morphine milligram equivalent (MME) of 90 MME/day or greater
- Access naloxone through an outpatient pharmacy in alignment with the preferred drug list

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SECTION 20 |
The NC Innovations Waiver

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

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

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

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

What does potentially eligible mean?
To be considered potentially eligible for N.C. Innovations requires documentation of an I/DD or a closely related condition, other than mental illness, and information about the resulting impairment to adaptive functioning.

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

What does clinically significant mean?

Clinically significant is usually defined as deficits in cognitive ability or adaptive function that is two standard deviations below what a typically developing person would score on standardized tests that are administered by psychologists. With intelligence tests, a score of 70 is two standard deviations below the average. Scoring is similar for standardized tests of adaptive functioning.

What is a closely related condition?

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

What are the six major life activities?

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

How long do individuals wait for an Innovations Waiver slot?

There are currently more than 1,000 individuals waiting for N.C. Innovations Waiver services in Vaya's region. Vaya is allocated a very limited number of slots each year by NCDHHS. The number of slots available varies based on several factors, including legislative actions regarding the state Medicaid budget, lifespan and support needs of current Waiver participants and geographic location. **Vaya cannot fund slots using our Waiver savings or other non-Medicaid funds.** Therefore, it is very difficult to predict the length of wait for Innovations services. While waiting, a person who is identified as potentially eligible may receive Medicaid (b) in lieu of services, Long-Term Community Supports (LTCS), State-funded I/DD services and/or services available due to the savings realized through managed care, such as Respite, Supported Employment and Community Networking funded through (b)(3) dollars.

Can someone be terminated from the Waiver?

There are several reasons why Vaya might terminate a slot. For example, Innovations participants must receive at least one service per month to avoid possible termination from the Waiver. These services are authorized because they were determined necessary to ensure the health and safety of the person receiving services. If they are not being provided, we must question whether the person remains eligible, being mindful of the long waiting list for services. We may also terminate a slot based on the participant/ LRP or family member's failure or refusal to comply with Innovations Waiver requirements, including, but not limited to, monitoring and service plan development and implementation.

Why is it called a Waiver?
It is called a "waiver" because CMS waived some of the requirements of the Social Security Act that traditionally apply to Medicaid. For example, the Innovations Waiver includes services and supports such as home modification and respite, which are not within the scope of services traditionally covered by Medicaid.

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

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

Will there be any changes to the Waiver?
The Waiver was amended multiple times, including effective August 1, 2013, and November 1, 2016, and renewed July 1, 2019. Any changes to the Waiver must be approved by CMS and are posted to the DHB website for public comment.

Does the Waiver contain any service limits?
Yes. Below is a summary of current limits. Note that some, but not all, limits may be exceeded for children under age 22 under the EPSDT benefit (discussed in Section 3 of this Manual).

- The Innovations Waiver has a **$135,000** annual budget ceiling per participant established by DHB and approved by CMS, except for documented need for individuals receiving Supported Living Level 3. Any request to exceed that limit will result in denial of the plan. If an individual's needs cannot be met under the $135,000 cost limit, they should be evaluated for referral and placement in an ICF-IID.
- Adults aged 22 and over who live in private homes cannot be authorized for more than 84 hours per week for any combination of Community Networking, Day Supports, Supported Employment and/or Community Living and Support.
- Children through age 21 who live in private homes cannot be authorized for more than 54 hours per week during the school year, or 84 hours per week when school is not in session, for any combination of Community Networking, Day Supports, Supported Employment and/or Community Living and Support. If the individual is 18 or older and graduated with a diploma (graduation with a degree/occupational course of study/GED indicating a standard course of study) then the individual may access the adult level of limits on sets of services.
- Adult and child beneficiaries who live in private homes with intensive support needs may request authorization from the LME/MCO for up to an additional 12 hours per day of Community Living and Support to allow for 24 hours per day of support. There are specific criteria for approval of this service, based on the individual's assessment results, and it must be reviewed every 90 days.

- Adults aged 22 and over who receive Residential Supports cannot be authorized for more than 40 hours per week for any combination of Community Networking, Day Supports and Supported Employment services.
- Children through age 21 who receive Residential Supports cannot be authorized for more than 20 hours per week during the school year, or 40 hours per week when school is not in session, for any combination of Community Networking, Day Supports and Supported Employment services.
- Individual Goods and Services cannot exceed $2,000 per plan year.
- Payment for attendance at classes and conferences may not exceed $1,000 per plan year for participants (under Community Networking).
- Reimbursement for attendance at classes and conferences may not exceed $1,000 per plan year for caregivers (under Natural Supports Education).
- Community Transition funds are limited to $5,000 over the duration of the Waiver.
- Assistive Technology Equipment & Supplies, as well as Home Modifications, are limited to expenditures of $50,000 over the duration of the Waiver.
- Vehicle Modifications funds are limited to expenditures of $20,000 over the duration of the Waiver.

Do all Waiver participants receive care management?

Yes, Vaya is required to assign a care manager to each Innovations Waiver participant. The care manager must conduct monthly monitoring visits to ensure services are being delivered appropriately and in accordance with the Care Plan and Waiver requirements, and to ensure the health and safety of individuals on the Waiver. The care manager also reviews the care plan for Innovations Waiver compliance, medical necessity, the member's health and safety needs, and service utilization (which is to remain within approved service authorization limits). Most monitoring is done face-to-face, although telephonic monitoring may occur as needed. The care manager also works with the family/LRP and service provider to develop and submit a Care Plan during the participant's birth month.

Is respite available under the Waiver?

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

Emergent Need Respite Beds shall serve as a temporary placement for adult individuals (age 18 and up) with I/DD and/or co-occurring MH/SU disorders who are either being diverted from or needing to be discharged from a hospital/emergency department setting and who are deemed stable and ready for discharge. The beds should be

a step-down from, or diversion to, a hospital. The site may also be used for individuals who live in group or family settings in order to maintain their current residential setting (and when Respite has been determined not available/appropriate). Referral for Emergent Need Respite is made through Innovation member's Care Manager.

Are there copayments for Innovations Waiver services?
No. Providers may not charge a co-payment for the services available through the N.C. Innovations Waiver.

Innovations Provider Responsibilities

PRIOR AUTHORIZATION

All Innovations Waiver services, except for crisis services, require prior authorization by Vaya. Innovations providers work with the assigned care manager to acquire prior authorization for services.

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

PERSON-CENTERED PLANNING

All Innovations providers are required to actively participate in the person-centered planning process leading to the development of the Care Plan. The results from the SIS® are utilized to guide the development of the Care Plan. The Care Plan outlines long-range outcomes for the person receiving Waiver services. The care manager, in collaboration with the person-centered planning team, is responsible for developing the long-range outcomes. The Member's care manager assists the Member in developing a care plan and explains options regarding the services available to the member. The Member's care manager based in a PIHP, AMH+, or CMA discusses with the Member the duration of the services expected by the Member and will ensure the proposed care plan requests authorization for each service at the duration requested by the member during the care plan year. Any requests for authorization of services are consistent with and incorporates the desires of the Innovations Waiver Member

and are reflected in the Innovations Waiver member's care plan, including the desired type, amount, and duration of services. The Innovations provider is responsible for developing the short-range goals that help the person receiving services achieve the identified long-range outcomes. Each short-range goal must include the strategies and interventions that direct support professionals will use to help the person receiving services achieve the goal. Innovations providers are responsible for monitoring delivery of the services authorized in the Care Plan. This includes regular review and, as necessary, adjustment of short-range goals to enable the person receiving services to achieve his/her highest success. Innovations providers are also responsible for ensuring direct support professionals receive supervision as required by DHB Clinical Coverage Policy No. 8P.

SCHEDULING

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

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

Deviations are made only at the request of the participant – not for provider convenience. Deviations must be documented by the provider agency. If there is to be a routine/ongoing deviation to the schedule due to changes in the participant's wants or needs, we recommend that the person-centered planning team update the weekly schedule to reflect the change. Such updates will encourage better communication between all parties. Under no circumstances should the schedule be amended based on the needs of the provider agency. Unless there is a change to the total number of hours per year, the updated schedule does not need to be submitted to or approved by Vaya's Utilization Management Department.

Once the schedule is established, only changes initiated by the participant or LRP may occur. Post-payment reviews and focused monitoring reviews will audit documentation, and a Plan of Correction may be required if there are findings related to deviations from the schedule. Clear notation on grids, services notes or on a QP communication log serve as evidence of adherence to the intent of the Innovations Waiver.

DOCUMENTATION

Innovations providers are required to document services as outlined in DHB Clinical Coverage Policy No. 8-P, the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, and as specified in this Manual. This includes, but is not limited to, adequate documentation of required staff training and service notes that include time in/time out.

BACK-UP STAFFING

During the person-centered planning process, an agency Back-up Staffing Plan is developed. Back-up staffing is not required for all Innovations Waiver services. For example, a Back-up Staffing Plan is not required for Respite services. The provider's Back-up Staffing Plan must be indicated in the "Agency Back-Up (mandatory)" section of the Care Plan. The Innovations provider is required to provide this information during the person-centered planning process. The Care Plan should also explain how the person receiving services needs shall be met when there is failure to provide back-up staffing, especially in the event of an emergency. The person receiving services cannot waive the Innovations provider's responsibility to identify the mandatory Back-up Staffing Plan. However, the person receiving services may choose to decline back-up staffing offered by an Innovations provider. Failure to provide mandatory agency back-up staffing is considered a Level I Incident. It is the responsibility of the provider agency to create an internal system to track their Level I Incidents. As outlined in 10A NCAC 27G .0602 - .0604, documentation of Level 1 Incidents must be available upon request by Vaya. In addition, providers must submit the Innovations Incident Reporting For Failure to Provide Back-Up Staffing Form on the 15th and the last day of the month to backupstaffing@vayahealth.com.

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

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

Service breaks are not considered Level 1 Incidents. Service breaks occur when a participant misses services for holidays, family vacations, weather conditions, illnesses or scheduling conflicts that cause a brief interruption in services. Service breaks must be documented by the Innovations provider and monitored by the care manager. Examples of service breaks include, but are not limited to:

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

MONITORING

Vaya complies with all requirements of the North Carolina Medicaid 1915(c) Home and Community Based Services (HCBS) Waiver (also known as the N.C. Innovations Waiver), the Behavioral Health (BH) and Intellectual/ Developmental Disability (IDD) Tailored Plan Contract awarded to Vaya by the N.C. Department of Health and Human Services, and the Department's BH IDD Tailored Care Management model. Care managers (referred to in the Innovations Waiver as "care coordinators") perform the monitoring of service delivery to verify:

- At least one service is utilized monthly, per Innovations or TBI Waiver requirements, except for children under age 21 with a diagnosis of autism spectrum disorder (ASD) who are actively engaged in a research-based intervention for the treatment of ASD
- Services are furnished in accordance with the care plan
- The Member is offered a choice of Innovations Waiver service providers
- The Member has access to services and the services meet the member's needs
- Issues of health, safety, and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-Innovations Waiver service needs (medical care) are addressed and documented as appropriate
- Service utilization, including underutilization and exceeding authorization
- Management of Individual and Family Directed Supports funds (if applicable) are not exceeded
- The Member is satisfied with the services being rendered

The purpose of monitoring of services and plan implementation is multidimensional; it provides opportunities for collaboration and enhancement of services/supports, assists the provider in identifying potential issues, and helps to identify areas where technical assistance is needed. At the conclusion of face-to-face monitoring visits, the care manager reviews any issues identified with the provider either live and/or by following up by phone. In some situations, the care manager may request clarification from the provider prior to making recommendations. As part of a team effort, the care manager proactively offers assistance and direction to the provider to ensure the member has access to quality services/supports and to improve the quality of services the member is receiving. The care manager encourages and assists the provider as they strive to meet positive outcomes for the member through a variety of avenues (i.e., taking an issue to the member's Care Team for discussion and resolution, alerting the provider to upcoming training that enhances the provider's ability to support the member, technical assistance, brainstorming with the provider to creatively meet the desires/needs of the member). If efforts to resolve identified issues with the provider are not successful or the issue continues to be present, the care manager completes a referral for investigation by the Vaya Provider Quality Assurance team. Each attempt at resolution and/or education is documented by the care manager.

Guidance for Using Protective Devices

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

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

1. During development of the Care Plan, the team will consider all material supports the person needs to live successfully in the community. These needs will be documented in Section B – Material Supports of the Risk/Support Need Assessment. The identified material support needs will be discussed by the Care Plan team. Some material support needs may be identified as a protective device. Each material support considered in the discussion must be identified as either a protective device or behavioral control in the medical/behavioral "What others need to know to best support me …" section of the Care Plan.
2. If a material support is identified as a protective device, the provider agency must review the material support(s) through their Human/Client Rights Committee annually in conjunction with development of the Care Plan.
3. If any member of the person's Care Plan team expresses concern that the material support is being used for behavioral control, the provider agency must review the material support through their Human/Client Rights Committee in accordance with 10A NCAC 27E .0104.
4. When the care manager is monitoring services, the participant/LRP signature on the Care Plan will constitute consent for material support items deemed protective devices by the Care Plan team. Material items that are deemed protective devices will not automatically be considered a restrictive intervention. However, if monitoring reveals that a protective device appears to be used for the purpose of behavioral control, the care manager will complete an investigation referral. If monitoring reveals potential abuse or neglect of the participant, the care manager will file an APS report with the applicable county Department of Social Services.

Relative as Direct Support Employee (RaDSE)

The N.C. Innovations Waiver is designed to leverage existing natural and community supports while fostering the development of stronger natural support networks. This enables Innovations participants to be less reliant on formal support systems. However, there are times when it is necessary for relatives/LRPs who share a home with the Waiver participant ("relative") to provide paid supports to ensure that the participant is able to remain in the home and community of his or her choice, particularly in our more rural communities. For this reason, DHB Clinical Coverage Policy No. 8P – NC Innovations allows for Innovations providers to employ relatives to provide Community Living and Support services within specific parameters. A relative is defined as an individual related by blood or marriage to the Waiver beneficiary but does not include biological or adoptive parents of a minor child, stepparents of a minor child and the spouse of a Waiver beneficiary. Waiver beneficiaries receiving Residential Supports are seen as being in an out-of-home placement and therefore not covered under the RaDSE policy in the Waiver.

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

- Is this about the participant's wishes, desires and needs, or is it about supplementing a family member's income?

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

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

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

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

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

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

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

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

The procedure for prior approval must be initiated by the Innovations provider through DocuSign®: (1) at least five business days prior to a new RaDSE requesting to provide services, and (2) on an annual basis, at least four calendar weeks prior to the start of the Waiver participant's plan year for a continuing RaDSE. Complete instructions and the link for beginning the process is available at https://providers.vayahealth.com. The form requires the Innovations provider to enter detailed information that will provide Vaya with all information necessary to approve or deny the request. Completion of the form will generate a prior approval request. The form will be reviewed for complete information and a decision rendered within 14 days. If the provider does not receive a timely response to its request, it is the provider's responsibility to follow up with Vaya's Provider Network Department to determine the status of the provider's request for the RaDSE and ensure it receives approval. Please note this form is required to be submitted annually and should be submitted in conjunction with the annual Care Plan. Approval in one year does not guarantee approval in subsequent years.

Vaya will review location information and attestations indicated on the request form, and an authorization decision will be made based on this information. For approvals, the Innovations provider will receive the approved DocuSign® form. For denials, the Innovations provider will receive the denied DocuSign® form and a formal letter that explains the decision. Rejections due to improper or incomplete requests will not be followed by a formal letter. If the request is rejected because of incomplete information, the provider may resubmit. **Please note that the N.C. Office of Administrative Hearings has determined that RaDSE decisions are not appealable, but you or the participant may file a grievance by calling the Member and Recipient Service Line 1-800-849-6127.**

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

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

Questions regarding RaDSE requirements may be addressed to: RaDSE@vayahealth.com.

Alternative Family Living (AFL) Requirements

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

- If the AFL caregiver serves more than one member or a member under age 18, the site must be licensed by DHSR. If the AFL is serving a single individual at an unlicensed site, it cannot provide services to another member while licensure is pending.
- A Back-up Staffing Plan must be in place, and the back-up staff must be employees of the AFL provider.
- The AFL provider and caregiver must cooperate with required annual health and safety reviews completed by the Vaya Contract Performance Unit.
- AFL providers must notify the assigned care manager prior to moving a member to a new AFL site. Failure to do so may result in adverse action, including, but not limited to, an overpayment finding and/or contract termination.
- All AFL providers must meet Vaya insurance requirements, including coverage for general liability, property and automobile liability.
- All documentation for service provision must meet requirements of Controlling Authority and be readily available for review upon request.
- 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 his/her relatives (by blood or marriage).

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SECTION 21 | Block Grant Requirements

If your agency receives federal Substance Abuse or Mental Health Block Grant funds from Vaya, you are responsible for meeting Federal Block Grant (FBG) requirements. It is your responsibility to know whether you receive these funds. To be eligible for FBG funds, you must be a nonprofit entity. You will be monitored by DMH/DD/SAS and Vaya for adherence to the FBG requirements. To ensure you are prepared to meet all requirements, please refer to the NCDHHS Block Grant audit information available on the Department's website.

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

Mental Health Block Grant Requirements

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

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

Substance Abuse Prevention and Treatment Block Grant Requirements

The following requirements must be implemented by Network Providers for individuals, services and/or programs funded with Federal Substance Abuse and/or Prevention Block Grant dollars, as well as certain programs funded with state service dollars. It is your responsibility to know the requirements that apply to your organization.

Please note that this section includes the general requirements that apply to all Substance Use Prevention and Treatment populations/ programs, as well as specific population/program requirements.

Additional requirements may be included in your contract with Vaya for specific programs or populations listed below. Please refer to the scope of work in your contract to verify any additional requirements. It is your responsibility to be aware of and comply with all requirements of your contracts with Vaya.

GENERAL REQUIREMENTS

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

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

- The organization must have in effect a secure system to protect member records from inappropriate disclosure in connection with any activity supported through FBG funds.
- The organization must have a Drug-Free Workplace Policy in effect.
- The organization must complete initial and subsequent N.C. Treatment Outcomes and Program Performance System (NC-TOPPS) at required intervals.

WOMEN'S SET-ASIDE FUNDING REQUIREMENTS

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

- Individuals served must have a principal or primary DSM-5 substance use diagnosis.
- Primary medical care needs are addressed, including referral for prenatal care and, while women are receiving such services, 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 that may address issues of relationships, sexual and physical abuse, parenting and childcare while women are receiving these services
- Sufficient case management and transportation to ensure that women and children have access to the services outlined above
- Timely admission or referral to appropriate services
- Member assessed for pregnancy
- Active outreach programs and priority admissions directed toward pregnant women who are substance abusers
- Written program description for pregnant women and women with dependent children that includes the following:
    - Treating the family as a unit
    - Provision for primary medical care and primary pediatric care services
    - Provision of gender-specific substance use disorder treatment
    - Provision for therapeutic interventions for children in the custody of women in treatment
    - Provision of sufficient case management and transportation to access services

REQUIREMENTS FOR PROGRAMS THAT PROVIDE SERVICES TO PREGNANT WOMEN

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

- The organization makes referrals for prenatal care and HIV and TB treatment services, if necessary.
- The organization provides counseling on the effects of alcohol and other drug use on the fetus.

REQUIREMENTS FOR PROGRAMS THAT PROVIDE SERVICES TO PERSONS IDENTIFIED AS IV DRUG USERS

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

PRIMARY PREVENTION SERVICES REQUIREMENTS

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

- Priority shall be given to populations that are at risk of developing a pattern of such abuse.
- The organization must ensure that programs receiving priority develop community-based strategies to discourage use of alcoholic beverages and tobacco by individuals to whom it is unlawful to sell or distribute such beverages or products.
- The organization must develop and implement comprehensive prevention programs that include a broad array of prevention strategies directed at individuals not identified to need treatment.
- Services must include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk of substance use.
- In implementing these provisions, prevention providers shall use a variety of the following defined strategies:
    - Information dissemination
    - Education
    - Alternatives
    - Problem identification and referral
    - Community-based process
    - Environmental
- The organization must use evidence-based prevention practices in the provision of services.
- The organization must deliver evidence-based programs to selected and indicated populations.
- Vaya will ensure that a total of 48 hours of Synar Amendment activities are conducted every 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 will notify each contracted prevention provider of the number of required hours that must be devoted to Synar Amendment activities per six months.

WORK FIRST/CPS SUBSTANCE ABUSE INITIATIVE REQUIREMENTS

This initiative serves DSS Work First Program, Food and Nutrition Services and Child Protective Services referrals.

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

JUVENILE JUSTICE SUBSTANCE ABUSE MENTAL HEALTH PARTNERSHIP (JJSAMHP) REQUIREMENTS

- Each member must meet the requirements of the designated target population/benefit plan of Child Substance Abuse Disorder.
- For uninsured members, the organization must require documentation of application for N.C. Medicaid.

- The organization must have a signed, valid consent for release of information with the Division of Juvenile Justice for each child being served.

A

APPENDIX A | Summary of Medicaid Covered Services & Clinical Coverage Policies

The table below contains Medicaid services and associated Clinical Coverage Policies that will be managed by Vaya. Full details on the policies are available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Clinical Coverage Policy 15
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)

[1]North Carolina's Medicaid State Plan is available here: https://medicaid.ncdhhs.gov/document/state-plan-under- title-xix-social-security-act-medical-assistance-program. Medicaid clinical coverage policies are available here: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

[2] The Department reserves the right to update the clinical coverage policies for covered benefits.

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**[1,2]
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a
Chiropractic services	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Clinic services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. §440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments
Dietary Evaluation and Counseling and Medical Lactation Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Durable medical equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members
Family planning services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Federally qualified health center (FQHC) services	SSA, Title XIX, Section 1905(a)(2) (C) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Freestanding birth center services (when licensed or otherwise recognized by the State)	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
Gynecology	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions
Hearing Aids	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
HIV case management services	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management
Home health services	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. §440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.l, Pages 13, 13a- 13a.4

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 3A
Home infusion therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy
Hospice services	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services
ICF-IID services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Innovations waiver services	8P: North Carolina Innovations
Inpatient hospital services	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. §440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services
Inpatient psychiatric services for individuals under age 21	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services
Inpatient and Outpatient BH services	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: Mobile Crisis Management Diagnostic Assessment

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	Intensive-In-Home Services Multisystemic Therapy Child and Adolescent Day Treatment Partial Hospitalization Substance Abuse Intensive Outpatient Program Outpatient Opioid Treatment Programs NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility- Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-6: Community Support Team (CST) North Carolina Clinical Coverage Policy 8D- 1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D- 2: Residential Treatment Services NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 8G – Peer Supports NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH)
Laboratory and X-ray services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Service NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services
Maternal Support Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
Non-emergent transportation to medical care	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 NC Medicaid Managed Care NEMT Policy Guidance
Nursing facility services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home
Occupational therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Office Based Opioid Treatment (OBOT)	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine- Naloxone
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Optometry services	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 441.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
Outpatient and residential BH services (only covered By Medicaid)	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	• Psychosocial Rehabilitation • Professional Treatment Services in a Facility Based Crisis System • Substance Abuse Comprehensive Outpatient Treatment Program • Substance Abuse Non-Medical Community Residential Treatment • Substance Abuse Medically Monitored Community Residential Treatment • Ambulatory Detoxification Services • Non-Hospital Medical Detoxification Services • Medically Supervised or Alcohol or Drug Abuse Treatment Center (ADATC) Detoxification • Community Support Team
Outpatient hospital services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Personal care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the- Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Physical therapy	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Physician services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. §440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.l, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therap NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1A- 27 Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty
Podiatry services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Prescription drugs and medication management	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The- Counter Products

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters Section V.B.2.iii. Pharmacy Benefits of the Contract
Private duty nursing services (PDN)	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age
Prosthetics, orthotics and supplies	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Reconstructive Surgery	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty
Respiratory care services	SSA, Title XIX, Section 1905(a)(20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services
Rural health clinic services (RHC)	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Services for individuals age 65 or older in an institution for mental disease (IMD)	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient BH Services
Speech, hearing and language disorder services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
Tobacco cessation counseling for pregnant women	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Transplants and Related Services	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy NC Clinical Coverage Policy 11B-1, Lung Transplantation

Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES[1,2]**
	NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device
Vision Services	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older

B

APPENDIX B | List of State-funded Behavioral Health, I/DD, and TBI Services

The tables below contain the list of State-funded behavioral health, I/DD, and TBI services managed by Vaya.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
All–Disability	1. Diagnostic assessment[22] 2. Facility based crisis for adults[23] 3. Inpatient BH services 4. Mobile crisis management 5. Outpatient services[24]	1. BH urgent care 2. Facility based crisis for children and adolescents
Adult Mental Health	1. Assertive community treatment (ACT)[25] 2. Assertive engagement 3. Case management[26] 4. Community support team (CST) 5. Peer Support Services[27] 6. Psychosocial rehabilitation	1. Partial hospitalization

[22] Diagnostic assessment may be provided through Telehealth.

[23] This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

[24] The BH I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.

[25] The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients

[26] This service may include critical time intervention, case management, and resource intensive case management (RICM).

[27] Peer supports include individual and group services.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
	7. Mental health recovery residential services[28] 8. Individual placement and support-supported employment (IPS-SE)[29] 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management	
Child Mental Health	1. High fidelity wraparound (HFW)[30] 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental health day treatment
I/DD and TBI[31]	1. Residential Supports 2. Day Supports Group 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment13 6. Respite 7. Adult Day Vocational Programs (ADVP)	1. TBI long term residential rehabilitation services
Substance Use Disorder - Adult	1. Ambulatory detoxification 2. Assertive engagement 3. Case management[32] 4. Clinically managed population specific high intensity residential services[33] 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports[34]	1. Social setting detoxification services

[28] This category of services may include group living and supervised living among other services.

[29] The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at: https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4364

[30] The Department intends allocate funding for slots for HFW services.

[31] I/DD and TBI care management will only be provided by the BH I/DD Tailored Plan.

[32] This service may include critical time intervention, case management, and RICCM.

[33] The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.

[34] Peer supports include individual and group services.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
	8. Substance use residential services and supports[35] 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment) 15. Community Support Team 16. BH Comprehensive Case Management	
Substance Use Disorder - Child	1. Multi-systemic therapy 2. SAIOP 3. Substance use residential services and supports 4. High fidelity wraparound (HFW) 9 5. Assertive Engagement	1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite

C

APPENDIX C | List of Behavioral Health, I/DD, and TBI Services Covered by the PIHP

- Inpatient behavioral health services
- Outpatient behavioral health emergency room services
- Outpatient behavioral health services provided by direct-enrolled providers
- Psychological services in health departments and school-based health centers sponsored by health departments
- Peer supports
- Partial hospitalization
- Mobile crisis management
- Facility-based crisis services for children and adolescents
- Professional treatment services in facility-based crisis program
- Outpatient opioid treatment
- Ambulatory detoxification
- Research-based BH treatment for Autism Spectrum Disorder (ASD)
- Diagnostic assessment
- Non-hospital medical detoxification
- Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
- Residential treatment facility services
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services
- Psychiatric residential treatment facilities (PRTFs)
- Assertive community treatment (ACT)
- Community support team (CST) (includes tenancy supports)
- Psychosocial rehabilitation
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment program (SACOT)
- Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Early and periodic screening, diagnostic and treatment (EPSDT) services
- Supported employment*

- Individual transition and support*
- Respite*
- Community living and supports*
- Community transition*

*North Carolina is currently in the process of developing a SPA to CMS to cover these services through 1915(i) authority.

D

APPENDIX D | Provider Advisory Council Code of Ethics

Vaya Health Provider Advisory Council (PAC) Code of Ethics

PREAMBLE

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

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

PURPOSE

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

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

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

CORE VALUES

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

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

ETHICAL PRINCIPLES

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

VALUE:
INTEGRITY – Provide accurate and truthful representation

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

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

ETHICAL PRINCIPLE:
Network Providers will represent their competence within their scope of practice. Network Providers will engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training and experience. Network Providers will allow individual staff to provide only those services that are within the staff member's competence, considering the employee's level of education, training and

experience. Network Providers will demonstrate compliance with state and federal rules, regulations and laws regarding standards for training and credentials for supports provided.

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

ETHICAL PRINCIPLE:
Network Providers will not participate in activities that produce a benefit for themselves over the individuals they support or may potentially support, always giving priority to professional responsibility over any personal interest or gain. Network Providers will make all reasonable efforts to prevent any incidents of abuse, neglect and exploitation. Abuse means the infliction of mental or physical pain or injury by other than accidental means, or unreasonable confinement or deprivation by an employee of services, which are necessary to the mental or physical health of the individual. Temporary discomfort that is a part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse. Neglect means the failure to provide care or services necessary to maintain the mental or physical health and wellbeing of the individual. Network Providers will promptly report and thoroughly investigate all allegations of abuse, neglect and exploitation. Under no circumstance will the support relationship between the program, staff and individuals receiving services, and/or their families or legal guardian, be exploited. Exploitation is defined as the illegal or unauthorized use of a service user or a service user's resources for another person's profit, business or advantage. Network Providers will train staff to recognize and report any suspected incidents of abuse and neglect and exploitation.

VALUE:
INDIVIDUAL VALUE, DIGNITY AND DIVERSITY – Provide supports and services, which promote respect and dignity of each individual served

ETHICAL PRINCIPLE:
Network Providers will comply with all federal and state rules and laws related to confidentiality and protected health information, including but not limited to, N.C.G.S. 122C; -52 through 122C-56, the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the HIPAA final administrative simplification regulations codified at 45 CFR Parts 160, 162 and 164; and 42 CFR Part 2. Network Providers will not discriminate in their relationships or services provided to individuals receiving supports, contractor and colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation or disability. Network Providers will provide individuals and families a means of submitting grievances that is fair and impartial. Network Providers will comply with N.C.G.S. § 35A – 1201, which allows for individuals who are adjudicated incompetent to be involved in decisions and choices that impact their lives.

Network Providers will make all reasonable efforts to ensure individuals and families participate in the development and revision of any plan for services. Network Providers will not abandon individuals and families. Network Providers will consistently demonstrate efforts to assure that their services eliminate the effects of any biases based upon individual and cultural factors. Network Providers will support the recovery and self-determination of each individual.

VALUE:
SOCIAL JUSTICE – Assure the rights of individuals receiving supports and others who make decisions regarding services are provided with complete information on which to make their choices

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

VALUE:
SOCIAL CAPITAL – Network Providers support the importance of social capital for each individual supported

ETHICAL PRINCIPLE:
Network Providers will support and promote opportunities for individuals they support to develop valued relationships with members of the community in which they live or work. Network Providers will support and promote opportunities for individuals they support they be treated with respect and dignity within the community they live or work. Network Providers will support and promote opportunities for individuals they support developing roles in the community in which they live or work.

VALUE:
PARTNERSHIP – Network Providers will work together in partnership to develop and achieve individual desired outcomes

ETHICAL PRINCIPLE:
Network Providers shall collaborate to share resources that enhance the functions of the Network to develop solutions for gaps in services and will work in partnership:

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

E

APPENDIX E |
Acronyms and Glossary

Commonly Used Acronyms and Glossary of Terms

1/12 shadow claim payment	Also known as a capitation payment. This is a predetermined payment established by contract. It is disbursed to the provider in 12 monthly payments and is intended as a prepayment for state-funded capitation services. Providers submit claims to Vaya the same as a fee-for-service claim. Providers are not paid for individual capitated service claims; the claims serve as proof that a service was rendered.
Abuse	Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
Access to Care	The ability to obtain an array of available and needed treatments, services and supports
Accreditation	Certification by an external entity that an organization has met a set of standards

Adverse Benefit Determination	As defined in 42 CFR 438.400(b), adverse benefit determination (previously referred to as a managed care "action") means: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; or (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
Adjudicate	A determination to pay or reject a claim
Ancillary Services	Services and supports designed to address Social Determinants, including but not limited to public welfare benefits such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC) program, utility assistance, food banks, housing, etc..
Appeal	A request for review of an Adverse Benefit Determination
Authorized service	Medically necessary services pre-approved by Vaya Health
Basic benefit plan	The basic benefit package includes services available to Medicaid-eligible individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services provide brief interventions for individuals with acute needs. The basic benefit package is accessed through a simple referral from Vaya through its screening, triage and referral system.
Capitation	Also known as sub-capitation. A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof a service was rendered.
Care manager (previously referred to as care coordinator)	Vaya employee assigned to conduct care coordination functions described at 42 CFR § 438.208(c), including referral, linkage, treatment and discharge planning

Catchment area or Region	Geographic service area; a defined group of counties
Claim	A request for reimbursement under a benefit plan for services
Clean claim	A “clean claim” is a claim that can be processed without obtaining additional information from the service provider or a third party. It does not include a claim under review for medical necessity or a claim from a provider under investigation by a governmental agency for fraud or abuse.
Client	Also referred to as “consumer”, “enrollee”, “member” “participant” or “patient”. Means an individual receiving services funded by Vaya or as defined in N.C.G.S. § 122C-3 (6).
CMO	Chief Medical Officer (Vaya)
CMS-1500	Health insurance claim forms. The CMS-1500 form is the official standard Medicare and Medicaid health insurance claim form required by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health & Human Services.
Coordination of Benefits (COB)	Process of obtaining payments from third-party payors (such as primary or secondary insurance) prior to billing the payor of last resort.
CSRA (formerly CSC)	The fiscal agent for NCDHHS that is responsible for the State’s MMIS
CUR	Client Update Request
DDE	Direct data entry, such as keying a claim directly into the Vaya MCIS
Denial	A request for payment that is received as clean and processed by Vaya but that does not meet all required criteria to be approved for payment. It is transmitted to the network provider via a remittance advice (RA) or other final notification of payment, payment denial, disallowance, payment adjustment or notice of program or institutional reimbursement.
DHB	N.C. Division of Health Benefits
Division of MHDDSAS	N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DSS	(N.C.) Division of Social Services or (county) Department of Social Services
Dx	Diagnosis

ECS	Electronic claims submission
EDI	Electronic data interchange
Eligibility	A determination that a person meets the requirements to receive services as defined by the payor
Enhanced benefit plan	Includes services that are available to Medicaid-entitled individuals and non-Medicaid individuals meeting medical necessity criteria. Enhanced benefit services are accessed through a person-centered planning process. Enhanced benefit services are intended to provide a range of services and supports that are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance use and with more complex service and support needs.
Enrollment	Action taken by the N.C. Division of Health Benefits (DHB) to add a Medicaid beneficiary's name to the monthly enrollment report. Also refers to an action by Vaya to add a non-Medicaid client to the Vaya non-Medicaid Health Plan.
Enrollment period	The timespan during which a beneficiary is enrolled with Vaya as a Medicaid waiver-eligible beneficiary
EOB	Explanation of benefits
Fee-for-service	A payment methodology that associates a unit of service with a specific reimbursement amount
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
HIPAA	The Health Insurance Portability and Accountability Act of 1996
I/DD	Intellectual and/or developmental disability
Licensure	A state or federal regulatory system for service providers to protect public health and welfare. Examples include licensure of individuals by professional boards, such as the N.C. Psychology Board or the N.C. Substance Abuse Professional Practice Board. Examples also include licensure of facilities that provide behavioral health and/or I/DD services by the N.C. Division of Health Service Regulation (DHSR). Licensure may apply to both individuals and facilities.

LME (Local management entity)	A local political subdivision of the state of North Carolina established under Chapter 122C of the North Carolina General Statutes that is responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.
Managed benefit	Services that require authorization from Vaya Utilization Management (UM)
MCO (managed care organization)	An umbrella term for health plans that provide healthcare in return for a predetermined monthly fee and coordinate care through a defined network of providers, practitioners and hospitals
N.C. Innovations Waiver	The North Carolina 1915(c) Home and Community-Based Waiver for people with I/DD.
NC START	N.C. Systematic Therapeutic Assessment, Respite and Treatment. NC START provides prevention and intervention services to adults with intellectual and/or developmental disabilities and complex behavioral health needs.
NC-SNAP	N.C. Support Needs Assistance Profile. NC-SNAP is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for developmental disability supports and services.
NC-TOPPS	N.C. Treatment Outcome Program Performance System. Refers to the program used by DMH/DD/SAS to measure outcomes and performance for substance use and mental health clients. NC-TOPPS captures key information on a person's current episode of treatment, aids in evaluation of active treatment services and provides data to meet federal performance and outcome measurement requirements.
Network Provider	A provider of services who has a contract in effect for participation in the Provider Network to provide services to Vaya Health Plan members.
NPI (National Provider Identification)	A National Provider Identifier or NPI is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare & Medicaid Services (CMS).
NPPES	National Plan and Provider Enumeration System
Out-of-area provider	A contracted provider who delivers services to a Vaya Health Plan member outside of the Vaya region

Out-of-network provider (OON)	A provider that has been approved as an out-of-network provider under Vaya's out-of-network policy and procedure and has executed a client-specific OON agreement with Vaya; however, these providers are not considered members of the Vaya provider network and are not available as service choices for Vaya members.
Overpayment	Any amount paid by Vaya to a provider to which the provider is not entitled, including, but not limited to, claims and expenses determined to be out-of-compliance. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.
Patient Monthly Liability (PML)	If a member's income is more than the cost of care in a long-term facility at the Medicaid rate, the member must contribute some income to the cost of care in the form of PML.
Place of service (POS)	Place of service; the facility or area where a service is rendered
Plan of Care	A single, unified plan that addresses the Member's integrated care needs related to Physical Health, Behavioral Health, Social Determinants, Ancillary Services and includes participation from all Healthcare Providers and other individuals/ organizations involved in the Member's life. The Plan of Care must address all applicable social, civil or legal requirements and does not negate a Member's right to privacy under federal and state law. The Plan of Care may also be referred to as a person-centered plan or an Individual Support Plan (ISP).
Population Health Management	The use of aggregated data to identify, analyze and impact specific health conditions, health disparities and improve member outcomes and reduce unnecessary costs through advocacy, investment in cost effective strategies to decrease disease prevalence and/or health disparities for identified populations, measuring and improving health outcomes, developing and implementing educational approaches and practice guidelines to improve clinical decision making and evidence-based practice in service and support approaches.
Primary diagnosis	The most important or significant condition of an individual at any time during the course of treatment in terms of implications for the individual's health, medical care and need for services
Prior authorization	The act of authorizing specific services before they are rendered

Re-adjudication	A claim that has completed the adjudication process is queued for another adjudication in the Vaya MCIS. Process can be initiated on a claim-by-claim basis by claims specialist or in a batch adjudication.
Reconsideration	A review of a previous finding or decision by Vaya based on the provider's reconsideration request and any additional materials presented by the provider.
Recoupment	Any formal action by Vaya to begin recovery of an overpayment with or without advance official notice by reducing future payments to a provider
Referral Screening Verification Process (RSVP)	The process used to determine whether a Medicaid beneficiary who is referred to or seeking admission to Adult Care Homes licensed under N.C.G.S. § 131D-2.4 is screened to determine whether the individual has a Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) as defined by the State of North Carolina's 2012 settlement with the U.S. Department of Justice.
Remittance advice (RA)	A document outlining claims status and payment that includes approved claims, denied claims, sub-capitated claims and recoupments (credit memos)
Replacement Claim	A replacement claim is essentially a new claim. It is submitted with a resubmit reference number, which is typically the claim header ID of the claim to be replaced. Once the replacement is submitted, the original referenced claim is automatically voided (reverted), and the new replacement claim replaces the original. This is used when a correction is needed on an approved original claim.
Revert	Also known as a 'void,' a revert renders the claim null and invalid. When a claim is reverted, it remains available for reference, but no further action can be taken with the claim. A revert can be performed standalone or as an automatic response to a submitted replacement claim.
Risk Stratification	Risk stratification is a process that helps identify members for CCM or care coordination by integrating a range of data sources calculated by various predictive models and current condition indicators. At Vaya, the risk stratification process focuses on behavioral health while incorporating physical health information to create a whole person driven stratification process. Risk stratification output can be used to monitor overall population health, highlight areas of major concern, and monitor outcomes over time.
Service Authorization Request (SAR)	A request for authorization of services. If approved, a SAR becomes an authorization.

Service location	Any location where a member may obtain a covered service from a Network Provider
Social Determinants	The World Health Organization defines social determinants as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
Spend-down	Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time
STR	Screening, triage and referral. This also refers to a page in the Vaya MCIS enrollment module.
Sub-capitated	Also known as “capitated.” A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof that a service was rendered.
Third party payor	An individual, entity or program that is or may be liable to pay for all or part of the payments made by Vaya to a provider
Third-party billing	Services billed to an insurance company, Medicare or other third-party payor
UB-04	The federal Office of Management and Budget and the National Uniform Billing Committee have approved the UB-04 claim form, also known as the CMS-1450 form. The UB-04 claim form accommodates the National Provider Identifier (NPI) changes.
Utilization Management (UM)	A process based on medical necessity criteria to regulate the provision of services in relation to the needs of individuals. This process should guard against under-utilization, as well as over-utilization, of services to assure the frequency and type of services fit individual needs.

List of Revisions

Vaya may update this Provider Operations Manual once per quarter in the event of substantive updates or revisions that impact providers or Vaya business. Unless directed by the Department, Vaya will not update this Provider Operations Manual more than once per quarter. Submissions of this provider manual to the Department do not replace or eliminate the requirement to annually review and update the provider manual. Vaya will review and update this Provider Operations Manual no less than annually to reflect changes to applicable federal and state laws, rules, and regulations; NCDHHS, NC Medicaid, or Vaya policies, procedures, bulletins, guidelines, or manuals. Vaya will submit this manual to NC Medicaid for approval no later than July 1 each year. Prior to the annual update of this Provider Operations Manual, Vaya staff will review all changes with the Provider Advisory Council, and providers will have 30 days to email suggested revisions to Vaya at manuals@vayahealth.com. This email may also be used throughout the year for suggestions for improvements to the manual. Your input will make this Provider Operations Manual more useful for all providers.

Vaya will provide you with notice of updates, and providers are also responsible for checking our website regularly for updates at https://providers.vayahealth.com/learning-lab/provider-manual. This Provider Operations Manual was submitted to NC Medicaid for approval 30 days after contract award and could not be used or distributed prior to final approval by NC Medicaid. In addition, this Provider Operations Manual must be updated within 15 days of notification or request by NC Medicaid, and corrections or revisions to any printed version must be included in the next printing. Any substantive updates or revisions to this Provider Operations Manual must be approved by NC Medicaid within 15 days of the change and may not be posted, printed, or enforced until approval has been received.

All future revisions to this manual will be listed here and will include a summary of the revision, section and page number of the revision, and date the revision was completed.