

**PROCUREMENT CONTRACT FOR PROVISION OF SERVICES
BETWEEN
TRILLIUM HEALTH RESOURCES
A BH I/DD TAILORED PLAN (TP)
AND
CONTRACTOR NAME
A PROVIDER OF BH I/DD TAILORED PLAN SERVICES**

**ARTICLE I:
GENERAL TERMS AND CONDITIONS**

1. **DEFINITIONS.** Any term defined by NCGS122C-3 shall have the same definition in this contract unless otherwise specified.
- A. "Amendment" means any change to the terms of a contract, including terms incorporated by reference, that modifies the fee schedules. A change required by federal or State law, rule, regulation, administration hearing, or court order or by the BH I/DD Tailored Plan Contract is not an amendment.
 - B. "Allowable Charges" means Contractors billed charges for services that qualify as covered services.
 - C. "Allowed Amount" means the amount designated in the Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular member, pursuant to this Contract or its Attachments.
 - D. "Behavioral Health Intellectual/Developmental Disability Tailored Plan (BH I/DD Tailored Plan)" has the same meaning as BH I/DD Tailored Plan as defined in N.C. Gen. Stat. § 108D-1(4). For purposes of this Contract, Trillium Health Resources is the BH I/DD Tailored Plan.
 - E. "Business Associate Agreement (BAA)" is a Contract between a HIPAA-covered entity and HIPAA Business Associate that allows disclosures of and protects personal health information (PHI) as required by HIPAA.
 - F. "Catchment area" shall mean the geographic service area and a defined grouping of counties.
 - G. "Clean Claim" means a claim that can be processed without obtaining additional information from the Contractor of the services or from a third party in order to adjudicate the claim. It does not include a claim under review for medical necessity, or a claim that is from a Provider that is under investigation by a governmental agency for fraud or abuse.
 - H. "Continuous Quality Improvement (CQI)" refers to a continuous effort to achieve measurable improvements in the efficiency, effectiveness, and accountability of an organization. This process is designed to improve the quality of services by tracking performance through outcome and performance measures. (The following link provides a description of what the Centers for Medicare and Medicaid Services (CMS) expects with regard to Continuous Quality Improvement: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf>)
 - I. "Contract" means a written agreement between an insurer and a Medicaid-enrolled provider for the provision of health care services by the provider on an in-network basis.
 - J. "Contractor" means **Contractor Name**, the provider of services pursuant to this Contract, including all staff and employees of Contractor. Contractor shall, as a party to this Contract, be considered a Network Provider.

- K. "Contract Year" means the period beginning when the BH I/DD Tailored Plan begins covering services under this Contract until the next June 30 and each subsequent twelve-month period thereafter.
- L. "Controlling Authority" means as defined in this Contract.
- M. "Cost-Sharing Amounts" means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Contract, when applicable.
- N. "Department" means the North Carolina Department of Health and Human Services (DHHS) and includes the Division of Health Benefits (DHB) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).
- O. "Emergency services" With respect to an emergency service, covered inpatient and outpatient services that:
- i. are furnished by a Contractor that is qualified to furnish such services; and
 - ii. are needed to evaluate or stabilize an emergency medical condition.
- P. "Health Care Provider" shall mean an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.
- Q. "Medical Record" means a single complete record, maintained by the Contractor of services, which documents all of the treatment plans developed for, and behavioral health services received by a Member.
- R. "Medical Necessity/Medically Necessary" is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.
- S. "Member", unless otherwise specifically indicated in the Contract, refers to (1) a Medicaid beneficiary whose Medicaid eligibility arises from residency in a county covered by the BH I/DD Tailored Plan or who is currently enrolled in and receiving benefits through the BH I/DD Tailored Plan and (2) a Recipient who is actively receiving a State-funded Service or State-funded function, paid for by State Funds or Federal Block Grant Funds.
- T. "Network Provider" shall mean as defined in 42 CFR 438.2.
- U. "Notice" means a written communication between the parties delivered by trackable mail, electronic means, facsimile, or by hand.
- V. "Party" refers only to the Contractor as defined in this Contract or the BH I/DD Tailored Plan; the two signatories to this contract.
- W. "Post stabilization services" or "Post stabilization care services" shall mean as defined in 42 CFR §422.113 and §438.114.
- X. "Prepaid Inpatient Health Plan (PIHP)" is an entity that (1) provides medical services to a Member under a contract with a State agency on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional service for its Members; and (3) does not have a comprehensive risk contract.
- Y. "Provider Operations Manual" or "Provider Manual" means the provider manual and any billing manuals adopted by the BH I/DD Tailored Plan and may include, without limitation, requirements relating to billing, credentialing, utilization management,

quality management, grievances and appeals, on-site reviews and State requirements, and may be unilaterally amended from time to time by the BH I/DD Tailored Plan.

- Z. “Regulatory Requirements” means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of BH I/DD Tailored Plan’s contracts with DHHS and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in the attachments to this Contract.

AA. “Unmanaged Visits” refers to visits not requiring prior authorization.

2. BASIC RELATIONSHIP.

- A. Contractor enters into this Contract with the BH I/DD Tailored Plan for the purposes of providing medically necessary MH/IDD/SA services to members enrolled with the BH I/DD Tailored Plan and agrees to comply with the Controlling Authority, the conditions set forth in this Contract and all Appendices or Attachments to this Contract. The Parties acknowledge and agree that a termination of this Contract is not an adverse determination as set forth-in G.S. 108C and that Controlling Authority allows this Contract to be terminated with or without cause. This Contract is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between the parties, their employees, partners, or agents but rather Contractor is an independent contractor of the BH I/DD Tailored Plan. Further, neither party shall be considered an employee or agent of the other for any purpose including but not limited to, compensation for services, employee welfare and pension benefits, workers’ compensation insurance, or any other fringe benefits of employment.

3. ENTIRE CONTRACT/ MODIFICATIONS/ADMENDMENTS.

- A. This Contract, consisting of the Procurement Contract for the Provision of Services and all Appendices and Attachments, constitutes the entire Contract between the BH I/DD Tailored Plan and the Contractor for the provision of services to Members. This contract shall supersede and replace any current Medicaid and/or State contract between the Contractor and BH I/DD Tailored Plan. Except for changes to Controlling Authority published by Centers for Medicare and Medicaid Services (CMS), the BH I/DD Tailored Plan, the Department, its divisions and/or its fiscal agent, any alterations, amendments, or modifications in the provision(s) of this Contract shall be in writing, signed by all parties, and attached hereto.
- B. Assignment.
- i. The Contractor’s duties and obligations under this contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
 - ii. The BH I/DD Tailored Plan shall notify the Contractor, in writing, of any duties or obligations that are to be delegated or transferred, prior to the delegation or transfer.
- C. Amendments.
- i. Subject to negotiation. Either Party may propose an amendment to this Contract for the purposes of negotiation and obtaining mutual consent to the amendment. Either Party may initiate negotiations pursuant to this subsection by submitting a proposed amendment to the notice contact of other Party. Such proposal shall include, at a minimum, a summary of the proposed amendment and the reason for the proposed amendment. The receiving Party agrees to consider and engage with the initiating Party for the purposes of attempting to reach mutual agreement. However, no such Amendment shall not be effective until reduced to writing and executed by both Parties.

- ii. Not subject to negotiation. BH I/DD Tailored Plan may propose amendments to the Contract, the terms of which are not subject to negotiation. BH I/DD Tailored Plan shall send any such proposed Amendments to the notice contact designated by Contractor pursuant to N.C. Gen. Stat. 58-50-275. Amendments shall be dated and include an effective date, labeled “Amendment (terms not subject to negotiation),” and signed by BH I/DD Tailored Plan. The proposed Amendment shall be effective on the date designated by BH I/DD Tailored Plan unless Contractor objects to the proposed Amendment in writing within sixty (60) days of receipt. If Contractor objects to the proposed Amendment, it shall not become effective and BH I/DD Tailored Plan shall be entitled to terminate the Contract upon sixty (60) days’ written notice to Contractor.

4. CONTROLLING AUTHORITY.

- A. This Contract is required by State and Federal law; including 42 C.F.R. §438.206 and §438.214 and shall be governed by the following, including any subsequent revisions or amendments thereto, (hereinafter referred to as the “Controlling Authority”):
 - i. Title XIX of the Social Security Act and its implementing regulations, N.C.G.S. Chapter 108A, the North Carolina State Plan for Medical Assistance, the applicable North Carolina Medicaid waiver(s) authorized by CMS; and
 - ii. The federal anti-kickback statute, 42 U.S.C. §1320a-7b(b) and its implementing regulations; the federal False Claims Act, 31 U.S.C. §3729 – 3733 and its implementing regulations; and the North Carolina Medical Providers False Claims Act, N.C. Gen. Stat. §108A-70-10 *et seq.*; and
 - iii. All federal and state Member rights and confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards, 45 CFR Part 164, alcohol and drug abuse patient records laws codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2, the Health Information Technology for Economics and Clinical Health Act (HITECH Act) adopted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and those State laws and regulations denominated in Appendix F; and
 - iv. Regulations concerning access to care, utilization review, clinical studies, utilization management, care management, quality management, disclosure, enrollment and credentialing activities as set forth in 42 CFR parts 438, 441, 455, and 456; and
 - v. State licensure and certification laws, rules and regulations applicable to Contractor; and
 - vi. Applicable provisions of Chapter 122C of the North Carolina General Statutes; and
 - vii. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. §108A-54.2; and
 - viii. The North Carolina Medicaid and Health Choice Provider Requirements, N.C. Gen. Stat. Ch. 108C.
 - ix. The Americans With Disabilities Act, Titles VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Vocational Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and subsequent amendments and regulations developed pursuant thereto, to the effect that no person shall, on the grounds of sex, age, race, religious affiliation, handicap, national origin, sexual orientation, and transgender status be subjected to discrimination in the provision of any services or in employment practices; and

- x. The Drug Free Workplace Act of 1988; and
 - xi. The requirements and reporting obligations related to the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS), Community Mental Health Services Block Grant (CMHSBG), Social Services Block Grant (SSBG) and accompanying state Maintenance of Effort (MOE) requirements; Projects to Assist in the Transition from Homelessness (PATH) formula grant; Strategic Prevention Framework – State Incentive Grant (SPF-SIG), Safe and Drug Free Schools and Communities Act (SDFSCA), and all other applicable federal grant program funding compliance requirements, if applicable.
 - xii. Regulatory Requirements and any other applicable federal or state laws, rules or regulations, in effect at the time the service is rendered and concerning the provision or billing of Medicaid reimbursable or State funded Mental Health, Intellectual and Developmental Disabilities and Substance Abuse (MH/IDD/SA) services; and
 - xiii. The BH I/DD Tailored Plan's Provider Operations Manual and the BH I/DD Tailored Plan contracts with the Department.
- B. Contractor agrees to operate and provide services in accordance with and pursuant to the Controlling Authority and the terms of this Contract. Contractor shall be responsible for keeping abreast of changes to Controlling Authority and will provide education and training to its staff and employees as it pertains to changes from the Controlling Authority as appropriate. Contractor shall develop and implement a compliance program in accordance with 42 U.S.C. §1396a(kk)(5).
- C. Contractor shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of the BH I/DD Tailored Plan, which may be set forth and/or summarized in the Provider Manual. Contractor's failure to comply with such policies could result in a denial, a reduction of payment to the Contractor, sanction as set forth in the Provider Manual, this Contract, and Regulatory Requirements, or termination of this Contract. The BH I/DD Tailored Plan shall make the Provider Manual available to the Contractor. In the event of a material change to the Provider Manual, the BH I/DD Tailored Plan will provide Contractor with at least thirty (30) days' advance written notice of such change. Such notice may be given through a periodic provider newsletter, or any other written method (electronic or paper). If there is any conflict between this Contract and the Provider Manual, this Contract will control.
- D. Contractor agrees to carry out its respective obligations under this Contract in accordance with Controlling Authority, the Provider Manual and all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Contractor's noncompliance with applicable Regulatory Requirements or this Contract, paybacks, sanctions, penalties or liquidated damages are imposed on BH I/DD Tailored Plan, BH I/DD Tailored Plan may, in its sole discretion, offset such amounts against any amounts due to the Contractor from BH I/DD Tailored Plan or require Contractor to reimburse BH I/DD Tailored Plan for such amounts.

5. TERM.

- A. This Contract is effective **X** to June 30, 202**X** and shall auto-renew annually on July 1 of each year thereafter. Either party may notify the other no less than sixty (60) days prior to July 1 of the current contract year if they do not wish to auto-renew for an additional term. This Contract shall not exceed the term of the BH I/DD Tailored Plan's contract with the Department. The BH I/DD Tailored Plan reserves the right to impose shorter time limits on the term of this Contract should Contractor fail to comply with the terms

of this Contract. Contractor understands that State and Federal statutory and regulatory requirements as set forth in this Contract or Controlling Authority may be changed or updated during the term and sequential terms of this Contract.

- B. The Parties' respective duties and obligations as to non-Medicaid services, set forth herein shall be dependent and contingent upon the appropriations, allocation, and availability of funds to BH I/DD Tailored Plan.

6. CHOICE OF LAW/FORUM.

The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the Parties to this Contract, are governed by the laws of North Carolina. The place of this Contract and all transactions and addendums relating to it, and their sites and forum, shall be the County of North Carolina in which the BH I/DD Tailored Plan's principal place of business is located, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

7. HEADINGS.

The paragraph headings used herein are for reference and convenience only and shall not enter into the interpretation hereof. Any attachments, appendices, exhibits, or schedules referred to herein or attached or to be attached hereto are incorporated herein to the same extent as if set forth in full herein.

8. COUNTERPARTS.

The Contract may be executed in two counterparts, each of which may be deemed an original.

9. NONWAIVER.

No covenant, condition, or undertaking contained in this Contract may be waived except by the written Contract of the Parties. Forbearance or indulgence in any other form by either party in regard to any covenant, condition or undertaking to be kept or performed by the other party shall not constitute a waiver thereof, and until complete satisfaction or performance of all such covenants, conditions, and undertakings have been satisfied, the other party shall be entitled to invoke any remedy available under the Contract, despite any such forbearance or indulgence.

10. DISPUTE RESOLUTION AND APPEALS.

The Contractor may file a complaint, grievance and/or appeal as set forth in the BH I/DD Tailored Plan Provider Manual or as otherwise set forth in the Controlling Authority.

11. SEVERABILITY.

If any one or more provisions of this Contract are declared invalid or unenforceable, the same shall not affect the validity or enforceability of any other provision of this Contract and such invalid or unenforceable provision(s) shall be limited or curtailed only to the extent necessary to make such provision valid and enforceable.

12. NOTICE.

Any notice to be given under this Contract will be in writing, delivered via trackable mail, postage prepaid, by electronic means, or by fax, addressed to the Contract Administrators designated by each party and noted at the address listed below or such other address as the party may designate by notice to the other party, and will be considered effective (i) on the day the notice is hand delivered; (ii) for certified or registered mail, the date on the return

receipt; (iii) for commercial courier service, the date of delivery; or (iv) for fax or electronic means, the date of confirmed transmittal.

Contractor Name Attn: 1 st St., Suite A (0000-000) Anywhere, N.C. 00000-000 555-555-5555 (PHONE) jdoe@Contractoremail.net	Trillium Health Resources Contracts Department 201 W. 1 st Street Greenville, NC 27858-1132 (855) 250-1539 (PHONE) Contracts@TrilliumNC.org
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13. ADMINISTRATIVE ACTIONS, SANCTIONS AND TERMINATION.

- A. Either party may terminate this Contract if Federal, State or local funds allocated to the BH I/DD Tailored Plan are revoked or terminated in a manner beyond the control of the BH I/DD Tailored Plan for any part of the Contract period. If Federal, State, or local funds allocated to the BH I/DD Tailored Plan are reduced in a manner beyond the control of the BH I/DD Tailored Plan, the BH I/DD Tailored Plan will notify Contractor and provide payment to Contractor for all pending and unpaid claims for services provided which were authorized by the BH I/DD Tailored Plan prior to the notification and for which Contractor has been qualified and credentialed. In the event of the BH I/DD Tailored Plan's insolvency based upon the revocation or termination of Federal, State or local funds, Contractor agrees to work collaboratively with BH I/DD Tailored Plan to transition administrative duties and records of Members to any entity that will be assuming the BH I/DD Tailored Plan's obligations to maintain continuity of care.
- B. Contractor understands, acknowledges and agrees that BH I/DD Tailored Plan may issue an educational (technical assistance) or warning letter, require a plan of correction, or impose administrative actions or sanctions against Contractor as the result of program integrity and any other monitoring activities. Possible administrative actions and sanctions are outlined in the Provider Manual and include but are not limited to increased monitoring/probation, limited or a suspension of referrals, moratorium on site or service expansion, payment suspension, site or service specific suspension or termination, full contract suspension, full contract termination and/or exclusion from participation in BH I/DD Tailored Plan's Provider Network. Contractor further understands, acknowledges and agrees that BH I/DD Tailored Plan is not required to issue an educational (technical assistance) or warning letter or plan of correction prior to the imposition of administrative actions or sanctions.
- C. In accordance with BH I/DD Tailored Plan accrediting body requirements, BH I/DD Tailored Plan may also suspend this Contract in response to any serious health or safety risk to Members identified by the BH I/DD Tailored Plan Chief Medical Officer or other Senior Clinical Staff Person, and such suspension shall remain in effect during the pendency of any investigation into such health or safety risk.
- D. This contract may be terminated without cause (i) at any time upon mutual consent of both parties or (ii) upon sixty (60) days' notice of termination by one of the contracting parties.
- E. The BH I/DD Tailored Plan is permitted to immediately suspend some or all activities under this Contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The BH I/DD Tailored Plan is permitted to immediately terminate this contract upon confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or upon termination of the BH I/DD Tailored Plan

contract by the State. The Contractor shall notify the BH I/DD Tailored Plan of members with scheduled appointments upon termination.

- F. The BH I/DD Tailored Plan may terminate this Contract for cause. Cause may include, but is not limited to:
- i. Issuance by the Department of a revocation or suspension of Contractor's license to operate or issues a Type A1 penalty against Contractor; issuance of a payment suspension against Contractor in accordance with 42 CFR §455.23; or issuance of a revocation of state and/or federal funding against Contractor in accordance with 42 C.F.R. § 455.410 and/or 10A NCAC 26C .0504; or
 - ii. Termination or suspension of contractor's participation in the Medicare program, NC Medicaid program, or another state's Medicaid program; or
 - iii. Termination of Contractor for cause from participation in another BH I/DD Tailored Plan's provider network or the provider network of any other managed care organization; or
 - iv. Any other loss of, or sanction against, required facility or professional licensure, accreditation or certification of the Contractor; or
 - v. Determination by BH I/DD Tailored Plan that Contractor fails to meet credentialing, certification, accreditation or licensure standards prescribed by Controlling Authority;
 - vi. Determination by BH I/DD Tailored Plan that Contractor has failed to provide services as specified in the Contract, including a failure to comply with Controlling Authority; or
 - vii. Determination by BH I/DD Tailored Plan that the conduct of Contractor or the standard of services provided threatens to place the health or safety of any Member(s) in jeopardy.
 - viii. Determination by BH I/DD Tailored Plan that Contractor is engaged in fraudulent or abusive billing, documentation or clinical practices; or
 - ix. Determination by BH I/DD Tailored Plan that Contractor has provided fraudulent, misleading or misrepresented information to BH I/DD Tailored Plan or any Member(s);
 - x. Failure by Contractor to cooperate with any investigation, audit or post-payment review conducted by BH I/DD Tailored Plan or failure to provide timely, complete and accurate documentation of services as required by this Contract; or
 - xi. Failure by Contractor to timely reimburse the BH I/DD Tailored Plan for overpayment(s) identified by the BH I/DD Tailored Plan or failure to comply with any payment plan authorized by the BH I/DD Tailored Plan for the repayment of any overpayment(s);
 - xii. Contractor's failure to have an Electronic Health Record as set forth in G.S. 90-414.4; or
 - xiii. Any other material breach of this Contract not described above.
- G. In the event BH I/DD Tailored Plan issues a sanction or terminates this Contract, Contractor may submit a request for reconsideration of administrative actions and sanctions as outlined in the Provider Manual.
- H. In the event that Federal and State laws should be amended or judicially interpreted so as to render the fulfillment of the Contract on the part of either party unfeasible or impossible, both the Contractor and the BH I/DD Tailored Plan shall be discharged from further obligation under the terms of this Contract, except as set forth by this Contract and for the settlement of pending and unpaid claims up to the date of termination or as otherwise required by this Contract.
- I. Change In Law. Except as set forth in the previous section, if there is a change in any law, regulation, rule, state or federal, which affects this Contract or the activities of either

party under this Contract, or any change in the judicial or administrative interpretation of any such law, regulation or rule and BH I/DD Tailored Plan reasonably believes in good faith that the change will have a substantial adverse effect on BH I/DD Tailored Plan operations or its rights or obligations under this Contract, then PIHP may amend this Contract as set forth in Art. I., Sec. 3.C.ii.

14. EFFECT OF TERMINATION.

- A. Upon notice of termination, a post-payment review of billing, documentation and other fiscal records may be performed and any adjustments for amounts due or owed to either party shall be added or deducted from the final Contract payments.
- B. In the event of termination, the Contractor shall submit all claims or registrations of putative Member(s) within ninety (90) days of the date of termination.
- C. The parties shall settle their respective debts and claims within the timeframes established within Article II Section 4 and Article IV.
- D. In the event of any audit or investigation, both parties shall settle their debts and claims within timeframes established by BH I/DD Tailored Plan from the completion of such audit or investigation and receipt of all final billing and required documentation. All payments provided herein shall be adjusted so as not to exceed the amount due for services actually rendered prior to the date of termination. If Contractor received advance payments for services not provided as of the date of termination, the Contractor shall promptly refund all excess funds paid within thirty (30) days.
- E. Contractor shall comply with Continuity of Care requirements set forth in Controlling Authority and provide notice to the BH I/DD Tailored Plan with respect to the closing of a facility. Contractor shall provide sixty (60) days written notice to the BH I/DD Tailored Plan of its intent to close a facility or discharge a Member(s) with intellectual or developmental disabilities who may be in need of continuing care as determined by the BH I/DD Tailored Plan and sixty (60) days written notice of intent to close a facility or discharge a Member(s) with a mental illness or substance abuse disorder who may be in need of continuing care as determined by the BH I/DD Tailored Plan. A transition plan shall be developed for each Member prior to being discharged and upon termination notify BH I/DD Tailored Plan of Member(s) with scheduled appointments.
- F. Survival. The expiration, termination, or cancellation of this Contract will not extinguish the rights of either party that accrue prior to expiration, termination, or cancellation or any obligations that extend beyond termination, expiration or cancellation, either by their inherent nature or by their express terms, including but not limited to Article I, Sections 4, 13; Article II, Sections 3, 4, 5, 7, 8, 9, 10, 12, 18, 19; Article III, Section 2; and Annex A as applicable.

15. NON-EXCLUSIVE ARRANGEMENT.

The BH I/DD Tailored Plan has the right to enter into a Contract with any other provider of services. The Contractor shall have the right to enter into other Contracts with any other BH I/DD Tailored Plan or third-party payers to provide services. The Parties shall cause their respective subcontractor(s) or other such entity performing services pursuant to this Contract on each Party's behalf, to comply with and abide by the Contracts, representations, warranties, acknowledgements, certifications, terms and conditions of this Contract and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on the Parties under this Contract (including each Attachment and Appendix), and the Provider Manual, in each case, to the same extent as if the subcontractor or other such entity were parties hereto. The parties shall be responsible for any breach of this Contract by any such subcontractor or other such entity. When a subcontractor meets the definition of a delegated

entity or partially delegated entity pursuant to BH I/DD Tailored Plans accreditation standards, BH I/DD Tailored Plan's prior approval of such delegation will be required.

16. NO THIRD PARTY CONTRACT RIGHTS CONFERRED.

Nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by any third party, against BH I/DD Tailored Plan, Contractor, or the Department. Furthermore, nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by BH I/DD Tailored Plan or Contractor against the Department.

**ARTICLE II:
RIGHTS AND OBLIGATIONS OF THE CONTRACTOR**

1. DISCLOSURE.

- A. The Contractor shall make those disclosures to the BH I/DD Tailored Plan as are required to be made to DHHS pursuant to 42 C.F.R. §455.104 and 106 and are required by the BH I/DD Tailored Plan's accrediting body. The BH I/DD Tailored Plan will share accrediting body requirements with Contractor upon request.
- B. To the extent, any of the above required disclosure information is captured in current or existing Medicare or NC Medicaid enrollment application documentation, the BH I/DD Tailored Plan shall accept electronic or paper copies of such documentation as meeting this requirement. Entities no longer enrolled in Medicaid or Medicare will be required to independently meet all disclosure requirements of this Paragraph, federal and state laws, rules and regulations, and the BH I/DD Tailored Plan's accrediting body.
- C. Provider ownership disclosure. The Contractor agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs.

2. LICENSES, ACCREDITATIONS, CREDENTIALING AND QUALIFICATIONS.

- A. The Contractor shall maintain all licenses, certifications, accreditations, and credentials sufficient to meet the BH I/DD Tailored Plan's Network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy. Contractor shall notify the Department within thirty (30) calendar days of learning of any adverse action initiated against any required license, certification, registration, accreditation and/or endorsement of the Contractor or any of its officers, agents or employees.
- B. Contractor shall not provide services until they are enrolled as a NC Medicaid provider with NC Tracks pursuant to 42 C.F.R. § 455.410. Contractor's failure to maintain enrollment is grounds for termination of this contract.
- C. The Contractor shall not bill the BH I/DD Tailored Plan:
 - i. For any services provided by Contractor during any period of revocation or suspension of required credentialing, licensure or accreditation of the Contractor's facility;

- ii. For any services provided by Contractor's staff during any period of revocation or suspension of the staff's required certification, licensure, or credentialing.
- D. The Contractor certifies that, at the time of execution of this Contract, neither Contractor nor any of its staff or employees are excluded from participation in Federal Health Care Programs under section 1128 of the Social Security Act, 42 C.F.R. § 455.410, and/or 42 CFR Part 1001. Should Contractor receive a notification of exclusion of Contractor or any of its staff or employees by the U.S. Office of Inspector General, CMS or any other State Medicaid program, Contractor shall notify the BH I/DD Tailored Plan of the exclusion and its plan for compliance as outlined in the Provider Manual.
- E. Contractor, upon written request by the BH I/DD Tailored Plan, shall provide proof of Contractor accreditation and copies of accreditation reports as part of the credentialing process.
- F. The BH I/DD Tailored Plan will conduct an assessment of the Contractor's qualifications to remain in the BH I/DD Tailored Plan's network at a minimum of once every three (3) years, unless otherwise required by the Department.
- G. Contractor shall complete the reenrollment/recredentialing process prior to Contract renewal and in accordance with the following:
 - i. During the provider credentialing transition period, no less frequently than every five (5) years.
 - ii. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

3. EVENT REPORTING AND ABUSE/ NEGLECT/ EXPLOITATION.

- A. Contractor shall use best efforts to ensure that Members are not abused, neglected or exploited while in Contractor's care.
- B. Contractor will comply with applicable critical incident and death reporting laws, regulations, policies, and event reporting requirements of national accreditation organizations to include reporting of all events or instances involving abuse, neglect or exploitation of Member as required by incident reporting guidelines by all applicable agencies and the Controlling Authority.
- C. Contractor shall not use restrictive interventions except as specifically permitted by the Member's individual treatment/habilitation plan or on an emergency basis in accordance with 10A NCAC 27E, 10A NCAC 13B, or as otherwise authorized in applicable Controlling Authority.
- D. BH I/DD Tailored Plan shall have the right to conduct its own investigation of any event reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the Contractor. The Contractor shall cooperate with all such investigative requests. Failure to cooperate is a material breach of this Contract. The BH I/DD Tailored Plan will provide the Contractor a written summary of its findings within timeframes established by BH I/DD Tailored Plan. During such an investigation, if any issues are cited as out of compliance with this Contract or federal or state laws, rules or regulations, the Contractor may be required to document and implement a plan of correction. Contractor may contest and appeal a determination that claims were paid in error as outlined in the BH I/DD Tailored Plan Provider Manual or as otherwise set forth in Controlling Authority.

4. BILLING AUDITS, DOCUMENTATION AND RECORDS RETENTION.

- A. Unmanaged Visits do not require prior authorization. All service delivery, both managed and unmanaged, require documentation and record retention in accordance with this section.

- B. The Contractor shall participate in and use best efforts to comply with the BH I/DD Tailored Plan's Utilization Management (UM) process, which may include requirements for pre-authorization, concurrent review and care management, credentialing review, and a retrospective utilization review of services provided for Members whose services are reimbursed by the BH I/DD Tailored Plan. The Contractor shall provide the BH I/DD Tailored Plan with all necessary clinical information for the BH I/DD Tailored Plan's UM process. For purposes of this Article II Section 4, Contractor shall provide specifically denominated clinical or encounter information required by the BH I/DD Tailored Plan to meet State and Federal monitoring requirements within fifteen (15) calendar days of the request, except that BH I/DD Tailored Plan may grant additional time to respond for good cause shown and depending upon the size and scope of the request. Additionally, Contractor will provide any documentation directly to the BH I/DD Tailored Plan for review when requested. Contractor may satisfy any request for information by either paper or electronic/digital means.
- C. The Contractor shall be responsible for completion of all necessary and customary documentation required for the services provided under this Contract in accordance with Controlling Authority.
- D. Documentation must support the billing diagnosis, the number of units provided and billed, and the standards of the billing code. The Contractor will be responsible for the adoption, assessment, collection, and disposition of fees in accordance with G.S. 122C-146.
- E. The Contractor shall maintain all documentation and records supporting Member's medical necessity for the services and shall provide it to the BH I/DD Tailored Plan for an investigation, audit or review upon request, within time frames established by the BH I/DD Tailored Plan, except that BH I/DD Tailored Plan may grant additional time to respond for good cause shown and depending upon the size and scope of the request.
- F. The Contractor agrees and understands that the BH I/DD Tailored Plan may inspect financial records concerning claims paid on behalf of Members, records of staff who delivered or supervised the delivery of paid services to Member demonstrating compliance with Controlling Authority, Members' clinical records, and any other clinical or financial items related to the claims paid on behalf of Members deemed necessary to assure compliance with the Contract. Contractor is also subject to audits, investigations and post-payment reviews conducted by the United States Department of Health and Human Services, including the Department's Office of Inspector General, CMS and the Department, or their agents.
- G. Equipment purchased with non-unit cost reimbursement funds, such as start up or special purpose funding, title to assets purchased under this Contract in whole or in part rests with the Contractor so long as that party continues to provide the services which were supported by the contract; if such services are discontinued, disposition of the assets shall occur as approved by the DHHS.
- H. Contractor agrees to maintain necessary records and accounts related to the Contract, including personnel and financial records in accordance with Generally Accepted Accounting Procedures and Practices to assure a proper accounting of all funds, including budget revisions. Contractor shall maintain detailed records of administrative costs and all other expenses incurred pursuant to the Contract including the provision of services and all relevant information relating to individual Member as required by Controlling Authority. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are resolved.
- I. At a minimum of once every two (2) years the Contractor will participate in an audit of paid claims conducted by the BH I/DD Tailored Plan. BH I/DD Tailored Plan shall conduct an entrance interview at the outset of any such audit. Any paid claims determined

to be out of compliance with Controlling Authority will require a repayment to the BH I/DD Tailored Plan as required by Controlling Authority. Any underpayments to Contractor will require payment by the BH I/DD Tailored Plan to the Contractor. Audits shall be arranged with the Contractor in advance, except when the BH I/DD Tailored Plan has received a credible allegation of fraud, the health, safety or welfare of Members is at risk, or the BH I/DD Tailored Plan is participating in a joint investigation with the Department, its Divisions, contractor(s) or another federal or state agency. At the conclusion of any such audit, the BH I/DD Tailored Plan shall conduct an exit conference with Contractor to discuss any tentative negative findings and provide Contractor written documentation of findings. Based upon results of the audit the Contractor may be subject to additional auditing and/or may be required to submit a plan of correction and /or may be required to remit funds back to the BH I/DD Tailored Plan as required by Controlling Authority. BH I/DD Tailored Plan may use statistical sampling and extrapolate audit results in accordance with Controlling Authority.

- J. In accordance with Controlling Authority, specifically 42 CFR §420.300 through §420.304, for any contracts for services the cost or value of which is \$10,000 or more over a 12-month period, including contract for both goods and services in which the service component is worth \$10,000 or more over a 12-month period, the Comptroller General of the United States, USDHHS, and their duly authorized representative shall have access to Contractor's books, documents, and records until the expiration of four (4) years after the services are furnished under the contract.
- K. The Contractor shall maintain a medical record and adhere to the federal record retention schedule for each Member served, either in original paper copy or an electronic/digital copy. Contractor shall maintain and share, as appropriate, medical records and other documentation in accordance with professional standards, NC DHHS *Records Management and Documentation Manual for Providers* (APSM 45-2), *Rules for MH/DD/SAS Facilities and Services* (APSM 30-1) and the *Basic Medicaid Billing Guide*, and any other applicable federal and state laws, rules and regulations, including but not limited to 42 CFR 438.208(b)(5). Contractor shall maintain confidentiality of member medical records and personal information and other health records as required by law. Medical records shall be maintained at the Contractor level; therefore, Members may have more than one record if they receive services from more than one Contractor. BH I/DD Tailored Plan shall monitor medical record documentation to ensure that the standards are met. BH I/DD Tailored Plan shall have the right to inspect Contractor records without prior notice. BH I/DD Tailored Plan shall also require Contractor to submit a plan for maintenance and storage of all records for approval by the BH I/DD Tailored Plan or transfer copies of medical records of Members served pursuant to this Contract to BH I/DD Tailored Plan in the event that the Contractor closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state or any other reason. The BH I/DD Tailored Plan has the sole discretion to approve or disapprove such plan. BH I/DD Tailored Plan shall not be held liable for any Contractor records not stored, maintained, or transferred pursuant to this provision so long as it has attempted, in good faith, to obtain a written plan for maintenance and storage or a copy of such records from the Contractor. If this Contract is terminated or if the Contractor closes network operations (but continues to have operations elsewhere in the State), the Contractor shall either: 1) provide copies of medical records of Members to the BH I/DD Tailored Plan, or 2) submit a plan for maintenance and storage of all records for approval by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan has the sole discretion to approve or disapprove such plan.
- L. Contractor shall make available to the BH I/DD Tailored Plan its accounting records for the purpose of audit by State authorities and, when required by general statute, have an

annual audit by an independent certified public accountant. A copy will be forwarded to the office of the State Auditor and the BH I/DD Tailored Plan.

5. FRAUD, ABUSE, OVER UTILIZATION AND FINAL OVERPAYMENTS, ASSESSMENTS OR FINES.

- A. Contractor agrees to provide, at no cost to BH I/DD Tailored Plan, prompt, reasonable and adequate access to BH I/DD Tailored Plan, any records, books, documents, and papers that relate to the Contract and/or Contractor's performance of its responsibilities under this Contract, for purposes of examination, audit, investigation, contract administration or any other purpose BH I/DD Tailored Plan deems reasonably necessary to perform its regulatory and oversight activities of the Contractor. BH I/DD Tailored Plan shall not be required to coordinate in advance with Contractor regarding Trillium's financial, clinical or program integrity auditing/monitoring activities.
- B. Contractor understands that whenever BH I/DD Tailored Plan receives a credible allegation of fraud, abuse, overutilization or questionable billing practice(s), the BH I/DD Tailored Plan is required to investigate the matter and where the allegation(s) prove Tailored Plans credible, the BH I/DD Tailored Plan is required to provide DHB with the Contractor name, type of provider, source of the complaint, and approximate dollars involved. Contractor agrees to cooperate in any such investigation, and failure to do so, may result in possible sanction up to and including termination of this Contract. Contractor understands that the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office or DHB, at their discretion, may conduct preliminary or full investigations to evaluate the suspected fraud, abuse, over utilization or questionable billing practices and the need for further action, if any. Fraudulent billing may include, but is not limited to, unbundling services, billing for services by non-credentialed or non-licensed staff, or billing for a service that Contractor never rendered or for which documentation is absent or inadequate.
- C. If the BH I/DD Tailored Plan determines Contractor failed to comply with Controlling Authority and has been reimbursed for a claim or a portion of a claim that the BH I/DD Tailored Plan determines should be disallowed, or that Contractor has been paid for a claim that was fraudulently billed to the BH I/DD Tailored Plan, the BH I/DD Tailored Plan will provide notice to the Contractor of the intent to recoup funds. Such notice of adverse action shall identify the Members name and dates of service in question, the specific determination made by the BH I/DD Tailored Plan as to each claim, and the requested amount of repayment due to the BH I/DD Tailored Plan. Contractor shall have sixty (60) days from date of such notification to either appeal the determination of the BH I/DD Tailored Plan or to remit the invoiced amount.
- D. If the BH I/DD Tailored Plan or Contractor determines that the Contractor has received payment from the BH I/DD Tailored Plan as a result of an error or omission, the BH I/DD Tailored Plan will provide notice to the Contractor of its intent to recoup funds related to errors or omissions. The BH I/DD Tailored Plan will provide an invoice to the Contractor including the Members name and dates of service in question. Contractor shall have sixty (60) days from date of such notification to either appeal the determination of the BH I/DD Tailored Plan or to remit the invoiced amount.
- E. When authorized by Controlling Authority, Contractor may request a reconsideration of a recoupment or overpayment identified pursuant to this Article II Section 5, as outlined in the BH I/DD Tailored Plan Provider Manual.
- F. Contractor understands and agrees that self-audits are encouraged by the BH I/DD Tailored Plan.
- G. Contractor shall be required to comply with BH I/DD Tailored Plan Utilization Management Programs, Quality Management Programs, and Provider Sanction

Programs, except to the extent that any of these programs conflict with Contractors professional or ethical responsibility or interfere with Contractor's ability to provide information or assistance to patients.

6. FEDERALLY REQUIRED CERTIFICATIONS AND ATTACHMENTS.

The Contractor shall execute and comply with all federally required certifications and attachments as applicable.

- a. Appendix A. Federal Assurances Certification Regarding Environmental Tobacco Smoke;
- b. Appendix B. Federal Assurances Certifications Regarding Lobbying;
- c. Appendix C. Federal Assurances Certification Regarding Drug-Free Workplace Requirements;
- d. Appendix D. Federal Assurance Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions;
- e. Appendix E. Outcomes and Reporting Measures;
- f. Appendix F. Agency/Practitioner or Group/Hospital/ICF Addendum;
- g. Appendix G. North Carolina Department of Health and Human Services Business Associate Agreement;
- h. Attachment A. Contracted Services and Approved Sites;
- i. Attachment B. Deficit Reduction Act;
- j. Attachment C. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members;
- k. Attachment D. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members;
- l. Attachment E. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
- m. Attachment F. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members
- n. Attachment G. Indian Health Care Providers

7. COMPLAINTS AND GRIEVANCES.

- A. The Contractor shall address all clinical concerns of the Members as related to the clinical services provided to the Members pursuant to this Contract. Contractor shall refer any unresolved Member concerns or requests to the BH I/DD Tailored Plan. In accordance with 10A NCAC 27G .0201(a)(18), the Contractor shall have in place a written policy for a Complaint and Grievance Process and procedures for review and disposition of Member complaints and grievances. The process shall be accessible to all Members and conducted in a fair and impartial fashion.
- B. The BH I/DD Tailored Plan may receive complaints directly from internal staff, Members, contracted providers, service providers, the Department or other third parties, which concern or pertain to the Contractor. If the BH I/DD Tailored Plan receives a complaint or grievance concerning the Contractor, the BH I/DD Tailored Plan shall process and resolve the complaint or grievance in accordance with Controlling Authority, including applicable State or Federal rules and regulations. In the event a complaint or grievance results in an investigation, review, or audit of Contractor by BH I/DD Tailored Plan, Contractor shall fully cooperate with all investigative requests of the BH I/DD Tailored Plan. Contractor's failure to cooperate with the BH I/DD Tailored Plan's investigation, review, or audit performed pursuant to this Article II Section 7, shall constitute a material breach of this Contract.

- C. Contractor will maintain a system to receive and respond timely to complaints received regarding the Contractor. The Contractor will maintain documentation on the complaint to include, at a minimum, date received, points of complaint, resolution and follow up provided, and the date complaint was resolved. The BH I/DD Tailored Plan will maintain documentation on all follow-ups and findings of any complaint investigation. The Contractor will be provided a written summary of the BH I/DD Tailored Plan's findings upon completion of the investigation, review, or audit performed pursuant to this Article II Section 7.

8. ACCESS TO CARE/ACCESS BY THE BH I/DD TAILORED PLAN.

- A. Contractor shall use its best efforts to timely notify BH I/DD Tailored Plan any time a Member is admitted into its facility, continuously provide authorized and appropriate services to each Member, and routinely update BH I/DD Tailored Plan regarding each Member receiving services from Contractor. Contractor shall coordinate the discharge of Members with the BH I/DD Tailored Plan to ensure that appropriate services are arranged following discharge and to link Members with other providers or community assistance. Contractor shall also allow appropriately credentialed BH I/DD Tailored Plan staff direct access to any Members, if requested by Member, determined to be clinically appropriate by the Member's treating physician, and/or requested in advance by the BH I/DD Tailored Plan. Contractor shall notify BH I/DD Tailored Plan representative in writing of all Member discharges at least thirty (30) days in advance of the anticipated date of discharge, if commercially reasonable, and in no event less than fourteen (14) days in advance of the anticipated date of discharge, unless exceptional circumstances necessitate a shorter notice.
- B. Contractor shall notify the BH I/DD Tailored Plan when a Member in a high acuity clinical setting is being discharged.
- C. The BH I/DD Tailored Plan understands the importance of Member-Contractor matching and that problems or incompatibilities arise in the therapeutic relationship. Nevertheless, Contractor shall with the consent of the Member, collaborate with Member, Member's family members, and the BH I/DD Tailored Plan to assure continuity of care and that there is no disruption of service. The BH I/DD Tailored Plan will work collaboratively with the Contractor to resolve any problems of continuity of care or in transferring the Member to another provider.
- D. Residential Substance Use Disorder Treatment Providers. If Contractor is contracted to provide residential substance use disorder treatment, Contractor is required to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- E. Commitment Orders. If Contractor provides services to Members pursuant to Commitment Orders, Contractor shall notify BH I/DD Tailored Plan of the Commitment Order upon receipt, in a manner designated by the BH I/DD Tailored Plan.
- F. Perinatal Care. If Contractor is a provider of perinatal care, Contractor shall ensure all pregnant women enrolled in managed care through the BH I/DD Tailored Plan receive a coordinated set of high-quality clinical maternity services consistent with the BH I/DD Tailored Plan's Pregnancy Management Program. A key feature of the program is the continued use of a standardized screening tool to identify and refer women at risk for an adverse birth outcome to the Care Management High Risk Pregnancy (CMHRP) program, a more intense set of care management services that will be coordinated and provided by Local Health Departments. If Contractor is an Obstetrician, Contractor shall comply with the Department's Pregnancy Management Program.
- G. Interpreting and Translation Services.
 - i. Contractor must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.

- ii. Contractor must ensure staff are trained to appropriately communicate with patients with various types of hearing loss.
- iii. Contractor shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

9. PROPRIETARY INFORMATION AND INTELLECTUAL PROPERTY.

Neither the Contractor nor the BH I/DD Tailored Plan shall publish or disseminate any advertising or proprietary business material either printed or electronically transmitted (including photographs, films, and public announcements) or any business papers and documents which identify the other party or its facilities without the prior written consent of the other party. Any documents, reports and other products, with the exception of any and all proprietary business papers and documents developed in connection with the performance of this Contract, shall be in the public domain and shall not be copyrighted or marketed for profit by the Contractor, the BH I/DD Tailored Plan, any individual, or other entity. Medical records, business records, and any other records related to the provision of care to and billing of Members shall not be in the public domain. Contractor consents to the use of its demographics, including practice specialties, phone numbers and addresses, in the BH I/DD Tailored Plan provider directory listings.

10. CONFIDENTIALITY.

For some purposes of the Contract (other than treatment purposes) the Contractor may be considered a "Business Associate" of the BH I/DD Tailored Plan as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as such will comply with all applicable HIPAA regulations for Business Associates as further expanded by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as "ARRA" (Public Law 111-5). Pursuant to Controlling Authority, specifically 45 C.F.R. § 164.506, Contractor and BH I/DD Tailored Plan may share a Member's protected health information (PHI) for the purposes of treatment, payment, or health care operations without the Member's consent

11. CONTRACTOR ACCESSIBILITY.

Contractor has an obligation to arrange for call coverage or other back-up to provide services in accordance with the BH I/DD Tailored Plan's standards to ensure service accessibility. The Contractor shall:

- a. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the Contractor serves only Medicaid beneficiaries;
- b. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
- c. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Contractor will accept all referrals meeting criteria for services negotiated, approved by BH I/DD Tailored Plan, and offered by Contractor when there is available capacity.
- d. Meet service availability and wait time standards as published in the BH I/DD Tailored Plan Provider Manual, established in compliance with 42 C.F.R. § 438.206 and with Department requirements for Network Adequacy Standards for Medicaid.

12. ADVOCACY FOR MEMBERS.

During the effective period of this Contract, the Contractor shall communicate freely with, provide information to, or advocate for, Members regarding the Members' mental health, intellectual and developmental disabilities, or substance abuse care needs, medical needs, and treatment options regardless of benefit coverage limitations. Contractor shall cooperate with the appeals and grievance procedures whenever a member files an appeal or grievance against Contractor or the BH I/DD Tailored Plan.

13. RESTRICTIONS ON THE EXPENDITURE OF SUBSTANCE USE PREVENTION, TREATMENT, AND RECOVERY SERVICES BLOCK GRANT (SUPTRS) FUNDS, COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (CMHSBG) FUNDS AND PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) FUNDS.

- A. CMHSBG funds shall not be used to provide inpatient services;
- B. SUPTRS funds are prohibited to be used to provide or purchase inpatient hospital services, except that SUPTRS funds may be used with the exception as described in 45 CFR 96.135 (c), along with documentation of the receipt of prior written approval of the DMH/DD/SAS Director of Financial Operations and the Chief of Addictions and Management Operations;
- C. SUPTRS and Mental Health Block Grant (MHBG) funds are prohibited to be used to make, or to allow to be made, any cash payments to any Members or intended Members of health or behavioral health services. The provision of cash or cash cards is strictly prohibited, as is the provision of gift cards, which are considered to be cash equivalents.
- D. SUPTRS and MHBG funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment;
- E. SUPTRS and MHBG funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement);
- F. SUPTRS and MHBG funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity;
- G. SUPTRS funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;
- H. SUPTRS funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, holding facilities, etc.);
- I. SUPTRS and MHBG funds are prohibited to be used towards the annual salary of any contractor or subcontractor, including BH I/DD Tailored Plan, provider, or Contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule;
- J. Contractors receiving federal funds are required to receive prior written approval from the Chief of the Addictions and Management Operations Section regarding the use of evidence-based program incentives, including the specification of the type(s) and equivalent dollar value(s) of any such nominal incentives offered, and the manner of utilization of any such approved incentives for clients, recipients, students, or other persons. "Nominal incentives" are restricted to those of no more than twenty-five dollars (\$25.00) in value per Member , per event. Programs are strictly prohibited from utilizing

any incentive items that could potentially be converted to cash, or that could be used for the purchase of any age-restricted product, such as tobacco, alcohol, drugs, weapons, or lottery tickets or any sexually oriented materials;

- K. Federal funds shall not be utilized for law enforcement activities;
- L. No part of any federal funding shall be used for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any state legislative body itself;
- M. No part of any federal funding shall be used to pay the salary or expenses of any grant or contract Member, or agent acting for such Member, related to any activity designed to influence legislation or appropriations pending before the Congress or any state legislature;
- N. PATH (as applicable) formula grant funds shall not be expended:
 - i. to support emergency shelters or construction of housing facilities;
 - ii. for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or
 - iii. to make cash payments to intended Members of mental health or substance abuse services, except as permitted by 45 CFR § 96.135(c).

14. TRAINING AND TECHNICAL ASSISTANCE.

Contractor providing MH/IDD/SA services paid for with Medicaid, State and/or Federal block grant funds shall attend all Orientation Sessions as determined by the BH I/DD Tailored Plan at no cost to the Contractor. The Contractor shall attend all mandatory trainings related to business practices at no charge to the Contractor. The Contractor shall attend clinical trainings provided/sponsored by the BH I/DD Tailored Plan or by outside parties required by provisions of this Contract, accreditation and/or licensure requirements at its cost. The Contractor shall demonstrate to the BH I/DD Tailored Plan its application of training information received in the delivery of services and compliance with the provisions of this Contract.

15. PRESERVATION OF DHHS PUBLIC FUNDS.

Contractor acknowledges funds used for provider payments are government funds. Contractor providing MH/IDD/SA services paid for with State and/or federal block grant funds shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies. Providers offering mental health and/or substance abuse services on an outpatient basis shall demonstrate good faith efforts to seek and/or maintain membership on major commercial insurance panels.

16. RESPONSE TO SURVIVORS OF DISASTERS AND OTHER HAZARDS.

If designated by the BH I/DD Tailored Plan, Contractor providing MH/IDD/SA services paid for with State and/or federal block grant funds, under the direction of the BH I/DD Tailored Plan and in coordination with the local Emergency Management agencies shall deploy behavioral health disaster responders to deliver behavioral health disaster services to survivors and other responders within the counties served by the BH I/DD Tailored Plan. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/teletypewriter (TTY) machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g. The Federal Emergency Management Agency (FEMA) Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined

that survivors or other disaster responders are in need of longer term mental health, developmental disabilities and/or substance abuse services Contractor's behavioral health disaster responders shall refer such persons in need to the BH I/DD Tailored Plan or its designee for further assistance.

17. CLINICAL OUTCOME MEASURES.

Contractor providing MH/IDD/SA services paid for with Medicaid, State, and/or Federal block grant funds shall complete DHHS required outcomes assessments on Members in accordance with DHHS guidelines and any subsequent changes thereto, including, but not limited to:

- a. Submission of NC Treatment Outcomes and Program Performance System (NC-TOPPS) data for individuals receiving mental health or substance abuse services, as specified in the NC-TOPPS Guidelines, and any subsequent changes thereto;
- b. Collection of outcome data for special populations such as Members transitioning from residential facilities as a result of the 2012 U.S. Department of Justice Settlement Contract with the State of North Carolina in accordance with the guidelines and the age and disability appropriate outcome instruments defined by the BH I/DD Tailored Plan; and
- c. Participation in and assistance with surveys of Contractor staff and Members conducted by DHHS and BH I/DD Tailored Plan in accordance with DHHS guidelines and any subsequent changes thereto.

18. INSURANCE.

- A. The Contractor shall purchase and maintain, at Contractors sole cost, Professional Liability Insurance as listed below from a company, or a self-insurance program that is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Self-insurance policies shall not be eliminated or reduced in coverage or limits below the stated minimums without thirty (30) days prior notice to the BH I/DD Tailored Plan.
 - i. Professional Liability. The Contractor shall purchase and maintain professional liability insurance protecting the Contractor and any employee performing work under the Contract for an amount of not less than \$1,000,000.00 per occurrence and proof of coverage at or exceeding \$3,000,000.00 in the annual aggregate.
- B. Contractor shall, purchase and maintain, at Contractors sole cost, additional insurance coverage as specified in Appendix F. BH I/DD Tailored Plan reserves the right to review its insurance limits annually and revise them as needed. Contractor shall obtain coverage that may only be suspended, voided, canceled or reduced by the carrier upon thirty (30) days prior written notice to Contractor, which written notice shall be forwarded by Contractor to BH I/DD Tailored Plan within five (5) business days. Upon request, Contractor shall submit certificates of coverage to BH I/DD Tailored Plan. Upon DHB's request, BH I/DD Tailored Plan shall submit copies of these certificates to DHB. Contractor acknowledges that:
 - i. Any loss of insurance shall justify the termination of this Contract in the BH I/DD Tailored Plan's sole discretion;
 - ii. Upon Contractor's notification of knowledge or notice of a claim, suit, criminal or administrative proceeding against Contractor and/or Practitioner relating to the quality of services provided under this Contract, BH I/DD Tailored Plan in its sole discretion shall determine within ten (10) days of receipt of notification whether termination of the Contract or other sanction is required; and

- iii. All insurance requirements of this Contract shall be fully met unless specifically waived in writing by both the BH I/DD Tailored Plan and Contractor.

19. CONTRACTOR PERFORMANCE AND DATA SUBMISSION.

Contractor shall participate in various quality improvement projects and activities as directed by the BH I/DD Tailored Plan and/or the Department. Contractor shall use best efforts to provide data to the BH I/DD Tailored Plan for the implementation of any studies or improvement projects required by the BH I/DD Tailored Plan and/or the Department. Participation may require Contractor to conduct data collection, data analysis, measures, and reporting. Contractor and BH I/DD Tailored Plan will mutually agree upon the data provided for these purposes, the format, and timeframe for provision of the data. Contractor data will be subject to review by the BH I/DD Tailored Plan and failure to submit timely reports or if measures fall below the set goal, Contractor may be subject to technical assistance, a plan of correction, or liquidated damages. BH I/DD Tailored Plan shall use, at its discretion, Contractor outcomes and performance measures for public reporting and audits as applicable. Contractor is encouraged to build or enhance their technology infrastructure to collect and analyze data, perform interventions and root cause analysis.

ARTICLE III: RIGHTS AND OBLIGATIONS OF THE BH I/DD TAILORED PLAN

1. REIMBURSEMENT.

- A. BH I/DD Tailored Plan will make available a copy of its policies and procedures to Contractor in compliance with G.S. §58-50-285. During the term of this Contract, BH I/DD Tailored Plan shall make available copies of its policies and procedures and prior to the execution of an amended contract with Contractor. BH I/DD Tailored Plan's policies and procedures shall not conflict with or override any term of this Contract including fee schedules referenced herein. In the event of a conflict between a policy or procedure and this Contract, the language in the Contract shall prevail.
- B. BH I/DD Tailored Plan will provide a mechanism that allows Contractor to verify member eligibility before rendering services and reporting of eligibility information to the BH I/DD Tailored Plan.
- C. The BH I/DD Tailored Plan shall reimburse Contractor for services provided to Members in accordance with the terms and conditions of this Contract, when such services have been authorized by the BH I/DD Tailored Plan, except in those instances where treatment authorization is not required.
- D. BH I/DD Tailored Plan shall have a reimbursement policy consistent with the requirements under G.S. 58-3-227(a)(5). BH/IDD Tailored Plan will apply claim edits based on guidelines from sources that may include, but not limited to CMS, American Medical Association (AMA), and State-specific policy and procedures, as set forth in the Provider Manual. In making payment determinations, Trillium shall utilize nationally recognized coding structures including the National Uniform Billing Code (NUBC), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD). Failure to follow appropriate coding guidelines may result in claim denial.
- E. The BH I/DD Tailored Plan shall advise the Contractor of any change in funding patterns that would affect reimbursement to the Contractor based on availability of the various

types of funds. Any changes to reimbursement shall be in writing to Contractor thirty (30) days prior to such change based on the availability of the various types of funds.

2. CONFIDENTIALITY OF CERTAIN CONTRACTOR INFORMATION.

- A. If the Contractor discloses confidential information, as that term is defined in G.S. § 132-1.2, to the BH I/DD Tailored Plan in connection with the Contractor's performance of this Contract, the BH I/DD Tailored Plan can protect the information from public disclosure to the extent permitted by G.S. § 132-1.2, if the Contractor takes one or more of the following steps before disclosing the confidential information to the BH I/DD Tailored Plan. If the Contractor determines that all of the information on any given document constitutes trade secret information, as that term is defined in G.S. § 66-152(3), the Contractor may designate the entire page as confidential by marking the top and bottom of the page with the word "CONFIDENTIAL" in upper-case bold-face type. If the Contractor determines that any given page of a document contains a mixture of trade secrets and non-confidential information, the Contractor may highlight the trade secrets and indicate in the margins that the highlighted text constitutes a confidential trade secret. By so marking any page, the Contractor warrants that it has formed a good faith opinion, upon advice of counsel or other knowledgeable advisors, that the items marked confidential meet the requirements of G.S. §§ 66-152(3) and 132-1.2(1). Pursuant to 1 NCAC 5B .1501 and 9 NCAC 6B .1001, price information may not be designated as confidential.
- B. The BH I/DD Tailored Plan may serve as the custodian of the Contractor's trade secrets but not as an arbiter of claims against the Contractor's assertion of confidentiality. If an action is brought pursuant to G.S. § 132-9 to compel the BH I/DD Tailored Plan to disclose information marked confidential, the Contractor agrees that it will intervene in the action through counsel and participate in defending the BH I/DD Tailored Plan, and NC DHHS and its officials and employees against the action. The Contractor agrees that it shall hold the State and its employees, officials, and agents and the BH I/DD Tailored Plan and its officials and employees harmless from any and all damages, costs, and attorney fees awarded against the BH I/DD Tailored Plan or the State in the action. The BH I/DD Tailored Plan agrees to give the Contractor prompt written notice of any action seeking to compel the disclosure of Contractor's trade secrets. The BH I/DD Tailored Plan and the State shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The BH I/DD Tailored Plan and the State shall have no liability to Contractor with respect to the disclosure of Contractor's trade secrets pursuant to an order issued by a court of competent jurisdiction pursuant to G.S. §132-9 or any other applicable law.

3. REFERRALS TO CONTRACTOR.

The BH I/DD Tailored Plan may refer Members to Contractor for services based on medical necessity and the Members' individual choice. The BH I/DD Tailored Plan reserves the right to refer Members to other providers, and there is no guarantee that referrals or authorizations will occur under this Contract.

4. UTILIZATION MONITORING.

The BH I/DD Tailored Plan shall monitor and review service utilization data related to the Contractor and the BH I/DD Tailored Plan's Provider Network to ensure that services are being provided in a manner consistent with Controlling Authority and the BH I/DD Tailored Plan's Contracts with the Department.

5. QUALITY ASSURANCE AND QUALITY IMPROVEMENT.

The BH I/DD Tailored Plan shall establish a written program for Quality Assessment and Performance Improvement (QAPI) in accordance with 42 CFR §438.240 that shall include Members, family members, and providers through a Global Quality Improvement Committee (GQIC), and the BH I/DD Tailored Plan shall:

- a. Provide Contractor with a copy of the current program and any subsequent changes within thirty (30) days of changes to the Quality Assessment and Performance Improvement Plan (QAPI);
- b. Measure the performance of Contractor and Member specific outcomes from service provisions based on the quality indicators. Examples include, but are not limited to, conducting peer review activities such as identification of practices that do not meet standards, recommendation of appropriate action to correct deficiencies, and monitoring of corrective action by providers;
- c. Measure outcomes in the areas of quality of life, functional status, and member satisfaction in collaboration with the Department and may involve the use of surveys administered by providers or involve development and piloting of novel survey instruments;
- d. Ensure administration of surveys by providers as required and requested by the Department;
- e. Ensure administration of the NC-TOPPS interview tool to members in a form and manner specified by the Department;
- f. Provide support to providers tailored to advance State interventions and ensure provider's ability to achieve the goals outlined in the Quality Strategy;
- g. Measure Contractor performance through medical record audits and clinical outcomes agreed upon by both Parties;
- h. Monitor the quality and appropriateness of care furnished to Members and assure compliance with the rules established by the Mental Health Commission, the Secretary of DHHS and G.S. 122C-142;
- i. Provide performance feedback to Contractor including clinical standards and the BH I/DD Tailored Plan expectations;
- j. Follow up with Contractor concerning grievances reported to BH I/DD Tailored Plan by Members; and
- k. Provide data about individual Members for research and study to the Contractor based on the parameters set by the BH I/DD Tailored Plan.
- l. Data to Contractor. BH I/DD Tailored Plan shall provide:
 - i. Performance feedback reports or information if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and UM requirements (in contract); credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall be provided by the BH I/DD Tailored Plan, allowing Contractor time to comply with such changes.

6. CARE MANAGEMENT/ COORDINATION OF CARE.

- A. The BH I/DD Tailored Plan shall ensure the coordination of care with each Member's primary care provider and any behavioral health provider enrolled to provide care for each Member. The BH I/DD Tailored Plan shall coordinate the discharge of Members with Contractor to ensure that appropriate services have been arranged following discharge and to link Members with other providers or community assistance.

- B. The BH I/DD Tailored Plan shall provide coordination of care to high-risk Members discharged from twenty-four hour care as set forth in BH I/DD Tailored Plan's contracts with the Department.
- C. If a Member requires medically necessary MH/IDD/SA services, the BH I/DD Tailored Plan shall arrange for Medicaid reimbursable services for the Member when possible.

7. AUTHORIZATION OF SERVICES.

- A. The BH I/DD Tailored Plan shall determine medical necessity for those services requiring prior authorization as set forth in Controlling Authority, including DHB Clinical Coverage Policies.
- B. Unless otherwise required by Controlling Authority, for those services requiring prior authorization, the BH I/DD Tailored Plan shall issue a decision to approve or deny a service within fourteen (14) calendar days after receipt of the request, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:
 - i. The Member requests the extension; or
 - ii. The Contractor requests the extension; or
 - iii. The BH I/DD Tailored Plan justifies to the Department upon request:
 - a) A need for additional information; and
 - b) How the extension is in the Member's interest.
- C. In those cases for services requiring prior authorization in which Contractor indicates, or BH I/DD Tailored Plan determines, that adherence to the standard timeframe could seriously jeopardize a Member's life or health or ability to attain, maintain, or regain maximum function, including but not limited to psychiatric inpatient hospitalization services, the BH I/DD Tailored Plan shall issue a decision to approve or deny a service within three (3) calendar days after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:
 - i. The Member requests the extension; or
 - ii. The BH I/DD Tailored Plan justifies to the Department upon request:
 - a) A need for additional information; and
 - b) How the extension is in the Member's interest.
- D. For those services requiring prior authorization, the BH I/DD Tailored Plan shall permit retroactive authorization of such services in instances where the Member has been retroactively enrolled in the Medicaid program or in the BH I/DD Tailored Plan program, or where the Member has primary insurance which has not yet paid or denied its claim. Retroactive authorizations include requests for deceased Members. The request for authorization must be submitted within ninety (90) days of primary denial or notice of enrollment.
- E. Amendment of Previous Authorizations for Outpatient Procedures. The BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a result of clinical findings or outcomes arising during the authorized outpatient procedure. Contractor shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.
- F. Upon the denial of a requested authorization, the BH I/DD Tailored Plan shall inform Member's attending physician or ordering provider of the availability of a peer to peer conversation, to be conducted within one (1) business day.
- G. For appeal information, please refer to the BH I/DD Tailored Plan Provider Manual.

- H. In conducting prior authorization, BH I/DD Tailored Plan shall not require Contractor to resubmit any data or documents previously provided to BH I/DD Tailored Plan for the Member's presently authorized services.
- I. CHAPTER 58 REQUIREMENTS. Pursuant to G.S. § 58-3-200(c), BH I/DD Tailored Plan shall not retract a determination that services, supplies or other items are covered under the BH I/DD Tailored Plan Benefit Plan after the services, supplies, or other items have been provided, nor shall BH I/DD Tailored Plan reduce payments for services, supplies or other items furnished in reliance on such a determination, except however that the BH I/DD Tailored Plan may retract such determination if its determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or the provider of the service, supply or other item.

ARTICLE IV: BILLING AND REIMBURSEMENT

1. CONTRACTOR PAYMENT.

- A. Payment under the Compensation Schedule. All payments under the Compensation Schedule are subject to the terms and conditions set forth in this Contract, the Provider Manual and any applicable billing manual and claim processing policies.
- i. The BH I/DD Tailored Plan's schedule of fees is available on the BH I/DD Tailored Plan website.
 - ii. By executing this Contract, Contractor certifies that BH I/DD Tailored Plan has made its schedule of fees available in compliance with G.S. §58-3-227(h).
- B. Compensation under this Contract. Compensation shall be the "Allowed Amount" except as otherwise provided in this Contract. The Allowed Amount for covered services is the rate floor as defined by the North Carolina Division of Health Benefits ("NCDHB") and North Carolina Department of Health and Human Services which is one hundred percent (100%) of the amount payable based on the BH I/DD Tailored Plan's respective Medicaid Fee-for-Service Fee Schedule and State-funded Fee Schedule on the date of service (the "Rate Floor"); unless, the Allowable Charge is less than the Rate Floor in which case both Parties mutually agree as an alternative reimbursement arrangement that the Allowed Amount will be equal to the Allowable Charge.
- C. Place of Service Pricing Rules. BH I/DD Tailored Plan fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).
- D. Fee Change Updates. Updated fee schedules shall become effective on the effective date of such fee schedule updates, as determined by the Payer ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, (i.e. the date on which such fee change is first used for reimbursement "Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payer is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.
- E. Code Change Updates. Payer utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month

following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

- F. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Member is responsible to pay under the Coverage Contract will be subtracted from the Allowed Amount in determining the amount to be paid.
- G. Payment for Multiple Procedures. To the extent applicable to the Contract, the parties agree to follow the multiple procedures code guidance set forth in the NC DHHS DHB Managed Care Billing Guidance to Health Plans applicable to services provided under this Contract. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Contract, any payment arrangement entered into between Contractor and a third-party vendor of such services shall supersede compensation hereunder.
- H. It is the Contractor's responsibility to verify the Member's Medicaid coverage prior to submitting claims to the BH I/DD Tailored Plan. If an individual presents for services who is not eligible for Medicaid and the Contractor reasonably believes that the individual meets Medicaid financial eligibility requirements, Contractor shall offer to assist the individual in applying for Medicaid.
- I. Member Billing. Contractor must notify any Member ahead of time and shall not bill the member for covered services, except for agreed upon specified coinsurance, copayments, and applicable deductibles. It is the Contractor's responsibility to specify the collection of any applicable deductibles, copayments, coinsurance, and fees for noncovered services. This provision shall not prohibit Contractor and Member from agreeing to continue non-covered services at the member's own expense, as long as the Contractor has notified the Member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the Member requests to receive the service.
- J. The BH I/DD Tailored Plan may unilaterally revise reimbursement rates under this Contract. Any changes to reimbursement shall be in writing to Contractor thirty (30) days prior to such change.
- K. Contractor shall comply with all terms of this Contract even though a third-party agent may be involved in billing the claims to the BH I/DD Tailored Plan. It is a material breach of the Contract to assign the right to payment under this Contract to a third party in violation of Controlling Authority, specifically 42 C.F.R. §447.10.
- L. Contractor acknowledges that the BH I/DD Tailored Plan and this Contract covers only those Medicaid reimbursable, and state and/or federal block grant funded, MH/IDD/SA services as referenced in Attachment A, and does not cover other services outlined in the North Carolina State Plan for Medical Assistance. The Contractor may bill any such other services for Medicaid recipients directly to the North Carolina Medicaid program.
- M. Contractor further understands that, regarding Medicaid services, there are circumstances that may cause a Member to be disenrolled from or by the BH I/DD Tailored Plan. If the disenrollment arises from Member's loss of Medicaid eligibility, the BH I/DD Tailored Plan shall be responsible for claims for the Member up to and including the Member's last day of eligibility. If the disenrollment arises from a change in the Member's Medicaid

County of residence, BH I/DD Tailored Plan shall be responsible for claims for the Member up to the effective date of the change in Medicaid County of residence. In any instance of Member's disenrollment, preexisting authorizations will remain valid for any services actually rendered prior to the date of disenrollment.

- N. Contractor shall bill BH I/DD Tailored Plan for all MH/IDD/SA services as described in Attachment A.
- O. For any provider subject to a rate floor, the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision. The BH I/DD Tailored Plan shall not consider any provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.
- P. Physician Advisor Use in Claims Dispute: The BH I/DD Tailored Plan shall accept Contractors designated, North Carolina licensed physician advisor with knowledge of the unit and care of the Member as Contractors approved representative for a claim or prior authorization in review or dispute.

2. SUBMISSION OF CLAIMS.

- A. The Contractor shall not submit claims or encounter data for services covered by Medicaid Managed Care and BH I/DD Tailored Plans directly to the Department.
- B. Claims must be submitted electronically either through HIPAA Compliant Transaction Sets; 837P – Professional claims, 837I – Institutional claims, or the BH I/DD Tailored Plan's secure web based billing system.
- C. Contractor's claims shall be compliant with the National Correct Coding Initiative effective at the date of service.
- D. Billing Diagnosis submitted on claims must be consistent with the service provided.
- E. If a specific service (as denominated by specific identifying codes such as CPT or HCPCS) is rendered multiple times in a single day to the same Member, the specific service may be billed as the aggregate of the units delivered rather than as separate line items.
- F. Parties shall be compliant with the requirements of the National Uniform Billing Committee.
- G. The BH I/DD Tailored Plan shall not reimburse Contractor for "preventable conditions" as set forth in 42 C.F.R. § 438.3(g).

3. PAYMENT OF CLAIMS.

- A. The BH I/DD Tailored Plan shall reimburse Contractor for approved Clean Claims for covered services requiring prior authorization within thirty (30) days of the date of receipt. Clean claims for emergency services which do not require prior authorization shall be reimbursed within thirty (30) days of the date of receipt.
 - i. If the BH I/DD Tailored Plan denies payment of a claim the BH I/DD Tailored Plan shall provide Contractor the ability to electronically access the specific denial reason.
 - ii. "Claims Status" of a claim shall be available within five to seven (5-7) days of the BH I/DD Tailored Plan receiving the claim.
 - iii. If the BH I/DD Tailored Plan determines that additional information in either original or certified copy form is required for making the approval or denial of the claim, BH I/DD Tailored Plan shall notify the Contractor within eighteen (18) days after the BH I/DD Tailored Plan received the claim. The Contractor shall have

- ninety (90) days to provide the additional information requested, or the claim shall be denied.
- iv. The BH I/DD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Contractor and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes but is not limited to Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. Claim attachments may be submitted electronically at the time of claim submissions. Upon BH I/DD Tailored Plan's receipt of the additional information from the Contractor, the BH I/DD Tailored Plan shall have an additional thirty (30) days to process the claim.
 - v. The BH I/DD Tailored Plan is not limited to approving a claim in full or requesting additional information for the entire claim. Rather, as appropriate, the BH I/DD Tailored Plan may approve a claim in part, deny a claim in part, and/or request additional information for only a part of the claim, as long as the BH I/DD Tailored Plan either approves, denies, or requests additional information for each part of the claim within the required eighteen (18) day period.
- B. The BH I/DD Tailored Plan will not reimburse Contractor for services provided by staff not meeting licensure, certification, credentialing, or accreditation requirements.
 - C. Contractor understands and agrees that reimbursement rates paid under this Contract are established by the BH I/DD Tailored Plan.

4. THIRD PARTY REIMBURSEMENT.

- A. Contractor will comply with N.C.G.S. §122C-146, which requires the BH I/DD Tailored Plan to make every reasonable effort to collect payments from third party payers.
- B. Contractor is required to bill all applicable third-party payers prior to billing the BH I/DD Tailored Plan. Each time a Member receives a service, Contractor shall determine if the Member has third party coverage that covers the service provided.
 - i. Medicaid benefits payable through the BH I/DD Tailored Plan are secondary to benefits payable by a primary payer, including Medicare, even if the primary payer states that its benefits are secondary to Medicaid benefits or otherwise limits its payments to Medicaid Members.
 - ii. The BH I/DD Tailored Plan makes secondary payments to supplement the primary payment if the primary payment is less than the lesser of the usual and customary charges for the service or the rate established by the BH I/DD Tailored Plan. The rate established aligns with the required rates paid by the BH I/DD Tailored Plan as well as inclusive the rate floor established by the Department.
 - iii. The BH I/DD Tailored Plan does not make a secondary payment if the Contractor is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.
 - iv. If Contractor or Member receives a reduced primary payment because of failure to file a proper claim with the primary payer, the BH I/DD Tailored Plan secondary payment may not exceed the amount that would have been payable if the primary payer had paid on the basis of a proper claim.
 - v. Contractor must inform the BH I/DD Tailored Plan that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.
- C. Contractor shall bill the BH I/DD Tailored Plan for third party co-pays and/or deductibles only as permitted by Controlling Authority.

5. UNDERPAYMENT/PAYMENTS POST APPEALS.

- A. If the BH I/DD Tailored Plan determines that Contractor has not been paid a claim or a portion of a claim that the BH I/DD Tailored Plan determines should be allowed for any reason, the BH I/DD Tailored Plan shall provide notice to the Contractor of the intent to pay the claims or portions of claims. Such notice of action shall identify the Member name and dates of service in question, the specific determination made by the BH I/DD Tailored Plan as to each claim, and the amount of payment due to the Contractor. Contractor shall have thirty (30) days from date of such notification to appeal the determination of the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall make such payment upon notice of intent to pay claims or portions of claims.
- B. Upon the conclusion of any 837, appeal or litigation that determines that BH I/DD Tailored Plan improperly failed to pay a claim or a portion of a claim to Contractor, the BH I/DD Tailored Plan shall remit the amount determined to be owed to Contractor.

6. PHARMACY COVERAGE.

- A. If Contractor is a pharmacy, Pharmacy may not, by or through a pharmacist acting on its behalf as its employee, agent, or owner, waive, discount, rebate, or distort a BH I/DD Tailored Plan Program copayment or a Member's coinsurance portion of a prescription drug coverage or reimbursement and if a Contractor, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to a Member that meets the BH I/DD Tailored Plan's terms and requirements the pharmacy shall provide its pharmacy services to all Members on the same terms and requirements of the BH I/DD Tailored Plan. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38.
- B. At least 60 days before the effective date of the BH I/DD Tailored Plan providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, the BH I/DD Tailored Plan shall notify, in writing, all pharmacies within the BH I/DD Tailored Plan's geographical coverage area and offer to the pharmacies the opportunity to participate with the BH I/DD Tailored Plan.
 - i. All pharmacies in such geographical coverage area shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs.
 - ii. The BH I/DD Tailored Plan shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the Members of the names and locations of pharmacies that are participating in the BH I/DD Tailored Plan as providers of pharmacy services and prescription drugs.
 - iii. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the BH I/DD Tailored Plan. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the BH I/DD Tailored Plan enters a particular county of the State.

Signatures:

IN WITNESS WHEREOF, the Parties, intending to be legally bound, has caused this Contract to be executed as the act of said party. Each individual signing below certifies that he or she has been granted the authority to bind the respective party to the terms of this Contract as of the Effective Date.

Joy Futrell, CEO
Trillium Health Resources
TIN: 56-0898928

Authorized Signer
Contractor
TIN:

This instrument has been pre-audited in the manner required by the Local Budget and Fiscal Control Act. General Statute 159.

Kellie Baker, CFO
Trillium Health Resources

REQUIRED ATTACHMENTS TO THE PROCUREMENT CONTRACT

The Contractor shall comply with the identified and attached federally required certifications and attachments below:

Annex A – Verbatim provisions not subject to negotiation
Appendix A – Federal Assurances Certification Regarding Environmental Tobacco Smoke
Appendix B – Federal Assurances Certification Regarding Lobbying
Appendix C – Federal Assurances Certification Regarding Drug-free Workplace Requirements
Appendix D – Federal Assurances Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions
Appendix E – Outcomes and Reporting Requirements
Appendix F – Agency
Appendix F – Practitioner/Group
Appendix F – Hospital
Appendix F – ICF
Appendix G – North Carolina Department of Health and Human Services Business Associate Agreement
Attachment A – Contracted Services and Approved Sites
Attachment B – Deficit Reduction Act
Attachment C – Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members
Attachment D – Pregnancy Management Program Policy for Medicaid and NC Health Choice Members
Attachment E – Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
Attachment F – Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members
Attachment G – Indian Health Care Providers

ANNEX A – VERBATIM PROVISIONS NOT SUBJECT TO NEGOTIATION

I. MEDICAID FUNDED SERVICES

- A. Compliance with State and Federal Laws. The Contractor understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the BH/IDD Tailored Plan's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The Contractor understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the BH I/DD Tailored Plan's contract with NC DHHS could result in liability for money damages, including civil or criminal penalties and sanctions under state and/or federal law.
- B. Hold Member Harmless. The Contractor agrees to hold the Member harmless for charges for any covered service. The Contractor agrees not to bill a Member for medically necessary services covered by the BH I/DD Tailored Plan so long as the Member is eligible for coverage.
- C. Liability. The Contractor understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the BH I/DD Tailored Plan, its employees, agents or subcontractors. Further, the Contractor understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the Contractor by the BH I/DD Tailored Plan or any judgment rendered against the BH I/DD Tailored Plan.
- D. Non-discrimination Equitable Treatment of Members. The Contractor agrees to render Provider Services to Members with the same degree of care and skills as customarily provided to the Contractor's patients who are not Members, according to generally accepted standards of medical practice. The Contractor and BH I/DD Tailored Plan agree that Members and non-members should be treated equitably. The Contractor agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
- E. Department authority related to the Medicaid program. The Contractor agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.
- F. Access to Contractor records.
 - 1. The Contractor agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the BH I/DD Tailored Plan and Contractor Contract and any records, books, documents, and papers that relate to the BH I/DD Tailored Plan and Contractor Contract/Agreement and/or the Contractor's performance of its responsibilities under this Contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:
 - i. The United States Department of Health and Human Services or its designee;

- ii. The Comptroller General of the United States or its designee;
 - iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee;
 - iv. The Office of Inspector General;
 - v. North Carolina Department of Justice Medicaid Investigations Division;
 - vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
 - vii. The North Carolina Office of State Auditor, or its designee;
 - viii. A state or federal law enforcement agency; and
 - ix. Any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.
2. The Contractor shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the BH I/DD Tailored Plan and/or the NC Department of Health and Human Services.
 3. Nothing in this Article I Section F shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.
- G. G.S. 58-3-225, Prompt claim payments under health benefit plans. Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018- 49 pertaining to Chapter 58 protections:
1. The Contractor shall submit all claims to the BH I/DD Tailored Plan for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service and, in the case of health care provider facility claims, within three hundred sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. When a Member is retroactively enrolled, the BH I/DD Tailored Plan shall not limit the time in which claims may be submitted by the Contractor to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider, health care provider facility, or pharmacy point of sale claims. However, the Contractor's failure to submit a claim within this timeframe will not invalidate or reduce any claim if it was not reasonably possible for the Contractor to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.
 - i. For Medical claims (including behavioral health):
 - a) The BH I/DD Tailored Plan shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the Contractor whether the claim is clean or pend the claim and request from the Contractor all additional information needed to process the claim. The BH I/DD Tailored Plan shall have the capability to request additional information via 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The BH I/DD Tailored Plan shall implement the capability for EDI 277 and electronic method (portal or email) no later than BH I/DD Tailored Plan Launch if approved by the Department. If an extension is needed, the BH I/DD Tailored Plan may submit a request to the Department's Contract

Administrator including the proposed implementation timeline and an explanation of how provider abrasion will be minimized during the extended implementation period.

- b) The BH I/DD Tailored Plan shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
- c) A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
- ii. For Pharmacy Claims:
 - a) The BH I/DD Tailored Plan shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.
 - b) A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.
- iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the BH I/DD Tailored Plan shall deny the claim per § 58-3-225 (d).
- iv. The BH I/DD Tailored Plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest if applicable).
- v. If the BH I/DD Tailored Plan fails to pay a clean claim in full pursuant to this provision, the BH I/DD Tailored Plan shall pay the Contractor interest. Late Payments will bear interest on the portion of the claim payment that is late at the annual rate of eighteen (18) percent beginning on the first day following the date that the claim should have been paid or was underpaid.
- vi. The BH I/DD Tailored Plan shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. 58-3-225(k).
- vii. The BH I/DD Tailored Plan shall pay the interest from subsections (v) and (vi) as provided in that subsection and shall not require the Contractor to request the interest or the liquidated damages.
- viii. For purposes of claims payment, the BH I/DD Tailored plan shall be deemed to have paid the claim as of the Date of Payment, and the BH I/DD Tailored Plan shall be deemed to have denied the claim as of the date the remittance advice is sent to the Contractor. The BH I/DD Tailored Plan defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to the Contractor or the date a paper check is mailed to the Contractor.

H. Contract Effective Date.

- 1. The effective date of any Contractor added under this agreement shall be the later of the effective date of this Contract or the date by which the Contractor's enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).

I. Tobacco-Free Policy.

- 1. Providers who may elect to implement a Tobacco-Free Policy Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings, or manufacturing sites that employ adults who receive group day services, are not required to develop or maintain a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco-free policy.

2. Reserved

3. Providers subject to Partial Tobacco-Free Policy

Starting January 1, 2027, contracts with Intermediate Care Facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings the Contractor shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

1. Use of tobacco products is prohibited indoors when the building or home in which the Contractor operates is under the Contractor's control as owner or lessee.
2. For outdoor areas of the property under, Contractor's control as owner or lessee, the owner or lessee shall:
 - i. Ensure access to common outdoor space(s) free from exposure to tobacco use; and
 - ii. Prohibit staff/employees from using tobacco products anywhere on property.
3. Contracts with Intermediate Care Facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

4. Providers subject to Full Tobacco-Free Policy

Starting January 1, 2027, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy:

- i. Contractor shall develop and implement a tobacco-free policy covering any portion of the property on which Contractor operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on Contractor from purchasing, accepting as donations, or distributing tobacco products to individuals Contractor serves.

II. STATE FUNDED SERVICES

- A. Compliance with state laws. The Contractor understands and agrees that it is subject to all state laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the BH I/DD Tailored Plan's State-funded Services contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state funds. The Contractor understands and agrees that any violation by a provider of a state law relating to the delivery of services pursuant to this contract, or any violation of the BH I/DD Tailored Plans contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under Federal or state law.
- B. Hold Recipient Harmless. The Contractor agrees to hold the recipient harmless for charges for any covered service. The Contractor agrees not to bill a recipient for

- medically necessary services covered by the BH I/DD Tailored Plan so long as the recipient is eligible for coverage.
- C. **Liability.** The Contractor understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the BH I/DD Tailored Plan, its employees, agents or subcontractors. Further, the Contractor understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the Contractor by the BH I/DD Tailored Plan or any judgment rendered against the BH I/DD Tailored Plan.
- D. **Non-discrimination Equitable Treatment of Recipients.** The Contractor agrees to render Provider services to recipients of State-funded Services with the same degree of care and skills as customarily provided to the Contractor's patients who are not recipients, according to generally accepted standards of medical practice. The Parties agree that recipients and non-recipients should be treated equitably. The Contractor agrees not to discriminate against recipients on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
- E. **Access to Contractor records.** The Contractor agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the BH I/DD Tailored Plan and Contractor Contract/Agreement and any records, books, documents, and papers that relate to the BH I/DD Tailored Plan and Contractor Contract/Agreement and/or the Contractor's performance of its responsibilities under this Contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:
- NC DHHS, its State-funded Services personnel, or its designee;
 - Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
 - The North Carolina Office of State Auditor, or its designee;
 - A state law enforcement agency; and
 - Any other state entity identified by NC DHHS, or any other entity engaged by NC DHHS.
- F. The Contractor shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the BH I/DD Tailored Plan and/or the NC DHHS.
- G. **Provider Ownership Disclosure.** The Contractor agrees to notify, in writing, the BH I/DD Tailored Plan and NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction.

Joy Futrell, CEO
Trillium Health Resources
TIN: 56-0898928

Authorized Signer
Contractor
TIN:

**APPENDIX A: FEDERAL ASSURANCES CERTIFICATION
REGARDING ENVIRONMENTAL TOBACCO SMOKE**

CONTRACTOR NAME

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this application, the Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any sub awards, which contain provisions for children's services, and that all sub grantees shall certify accordingly.

Contractor: Legally Authorized Representative

**APPENDIX B: FEDERAL ASSURANCES CERTIFICATION
REGARDING LOBBYING**

CONTRACTOR NAME

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, and U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Contractor: Legally Authorized Representative

**APPENDIX C: FEDERAL ASSURANCES CERTIFICATION REGARDING
DRUG-FREE WORKPLACE REQUIREMENTS**

CONTRACTOR NAME

We certify our Agency will comply with the Drug Free Workplace Act of 1988 as follows:

1. Definitions. As used in this provision,

- A. **Controlled substance** means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CFR 1308.1- 1308.15.
- B. **Conviction** means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.
- C. **Criminal Drug Statute** means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, and possession or use of any controlled substance.
- D. **Drug-Free Workplace** means a site for the performance of work done in connection with a specific contract at which employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.
- E. **Employee** means an employee of a Contractor directly engaged in the performance of work under a Government contract.
- F. **Individual** means an offeror/contractor that has no more than one employee including the offeror/contractor.

2. By submission of its offer, the offeror, if other than an individual, who is making an offer that equals or exceeds \$25,000, certifies and agrees, that with respect to all employees of the offeror to be employed under a contract resulting from this solicitation it will:

- A. Publish a statement notifying such employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition.
- B. Establish a drug-free awareness program to inform such employees about:
 - The dangers of drug abuse in the workplace.
 - The Contractor's policy of maintaining a drug-free workplace.
 - Any available drug counseling, rehabilitation, and employee assistance programs.
 - The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
- C. Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph B-1 of this provision.
- D. Notify such employees in the statement required by subparagraph B-1 of this provision, that as a condition of continued employment on the contract resulting from this solicitation, the employee will:
 - Abide by the terms of the statement; and
 - Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.
- E. Notify the contracting officer within ten (10) days after receiving notice under Subdivision B-4 of this provision, from an employee or otherwise receiving actual notice of such conviction; and
- F. Within thirty (30) days after receiving notice under subparagraph B-4 of this provision of or remedial measures on any employee who is convicted of drug abuse violations occurring in the workplace:
 - Take appropriate personnel action against such employee, up to and including termination;

or

 - Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by Federal, State, or local health, law enforcement, or other appropriate agency.
- G. Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs B-1 through B-6 of this provision.

3. By submission of its offer, the offeror, if an individual who is making an offer of any dollar value, certifies and agrees

that the offeror will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in the performance of the contract resulting from this solicitation.

4. Failure of the offeror to provide the certification required by paragraph B or C of this provision, renders the offeror unqualified and ineligible for award. (See FAR 9.104-1 (g) and 19.602-1 (a) (2) (i).
5. In addition to other remedies available to the Government, the certification in paragraphs B and C of this provision concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.
6. Further, false certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment (Section 4 CFR Part 85, Section 85.615 and 86.620).

Contractor: Legally Authorized Representative

**APPENDIX D: FEDERAL ASSURANCES CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND
VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS**

CONTRACTOR NAME

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to which the proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency of which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.
 - A. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
 - B. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Contractor: Legally Authorized Representative

APPENDIX E: OUTCOMES AND REPORTING REQUIREMENTS

CONTRACTOR NAME

1. OUTCOMES.

CONTRACTOR providing MH/IDD/SA services paid for with Medicaid, State, and/or Federal Block Grant funds shall complete DHHS required outcomes assessments on clients in accordance with DHHS guidelines and any subsequent changes thereto, including, but not limited to:

- A. submission of NC-TOPPS data for individuals receiving MH or SA services, as specified in the NC-TOPPS Guidelines and any subsequent changes thereto;
- B. collection of outcome data for special populations such as Member(s) transitioning from residential facilities as a result of the 2012 U.S. Department of Justice Settlement Agreement with the State of North Carolina in accordance with the guidelines and the age and disability appropriate outcome instruments defined by BH I/DD Tailored Plan and
- C. participation in surveys of Contractor staff and members conducted by DHHS and BH I/DD Tailored Plan in accordance with DHHS guidelines and any subsequent changes thereto.

2. REPORTING REQUIREMENTS.

Please use the grid below to track your specific reporting requirements – see below as an example for BH I/DD Tailored Plan contacts

Form/Report	Special Requirements	Due Date	BH I/DD Tailored Plan Contact	Contact Email
			Data Manager	Reports@TrilliumNC.org

Contractor: Legally Authorized Representative

APPENDIX F: AGENCY

CONTRACTOR NAME

1. DISCLOSURES AND ENROLLMENT.

- A. The Contractor shall make those disclosures to the BH I/DD Tailored Plan as are required to be made to DHB pursuant to 42 C.F.R. §455.104 and 106 and are required by the BH I/DD Tailored Plan accrediting body. BH I/DD Tailored Plan will share accrediting body requirements with Contractor upon request. The Contractor shall disclose any affiliation, by contract or otherwise, with any other provider, or independent contractor to perform any of the duties, responsibilities or obligations of this Contract.
- B. The Contractor shall disclose to the BH I/DD Tailored Plan Contractor's trade name (d/b/a) or any other name Contractor may use to perform the duties and obligations under this Contract.
- C. Contractor, on behalf of itself, its affiliates, subsidiaries, heirs, successors, assigns, partners, directors, members, managers, agents, representatives, employees, shall report to the BH I/DD Tailored Plan any sanctions under the Medicare or Medicaid Programs, including but not limited to overpayments, recoupments, fines, paybacks, suspensions, terminations, lawsuits, insurance claims or payouts, as well as any adverse actions by federal or state regulatory agencies within the previous five (5) years.
- D. Contractor's Licensed Practitioners and Licensed Practitioner Associates may be reimbursed for services to Member(s) upon approval of the practitioner's credentials retroactive to the date of receipt of a complete and accurate Contractor application.
- E. To the extent any of the above required disclosure information is captured in current or existing Medicare or NC Medicaid enrollment application documentation, the BH I/DD Tailored Plan shall accept electronic or paper copies of such documentation as meeting this requirement. Entities no longer enrolled in Medicaid or Medicare will be required to independently meet all disclosure requirements of this Paragraph, federal and state laws, rules and regulations, and the BH I/DD Tailored Plan accrediting body.

2. DELIVERY OF SERVICES.

- A. Contractor is required to serve Member(s) within sixty (60) calendar days from the effective date of this Contract. If Contractor has not accepted and delivered services to Member(s) within sixty (60) calendar days from the date of execution of this Contract, the Contract may be terminated without further notice.

3. CARE COORDINATION.

- A. Contractor shall allow BH I/DD Tailored Plan care coordination staff direct access to Member(s) served under this Contract. Contractor shall allow designated BH I/DD Tailored Plan care coordination staff to attend any treatment team and discharge planning meetings regarding Member(s) served under this Contract, with advanced notice and consistent with BH I/DD Tailored Plan's responsibility to provide care coordination to Member(s) with special healthcare needs.
- B. Upon request of BH I/DD Tailored Plan, Contractor shall designate qualified care coordination staff to participate in interdisciplinary team meetings facilitated by the BH I/DD Tailored Plan that involve Member(s) served under this Contract.
- C. Contractor shall provide information pertinent to the development of an Individual Service Plan (ISP) for persons with Intellectual or other Developmental Disabilities, and a Person Centered Plan (PCP) for persons with Mental Health or Substance Abuse Disorder or shall directly participate in the planning process.
- D. Contractor shall be responsible for the development of treatment and/or supports strategies to address assigned areas of responsibility from the PCP or ISP.

Contractor: Legally Authorized Representation

APPENDIX F: PRACTITIONER/GROUP

CONTRACTOR NAME

1. DISCLOSURES AND ENROLLMENT.

- A. The Contractor shall make those disclosures to the BH I/DD Tailored Plan as are required to be made to DHB pursuant to 42 C.F.R. §455.104 and 106 and are required by the BH I/DD Tailored Plan accrediting body. BH I/DD Tailored Plan will share accrediting body requirements with Contractor upon request. The Contractor shall disclose any affiliation, by contract or otherwise, with any other provider, or independent contractor to perform any of the duties, responsibilities or obligations of this Contract.
- B. The Contractor shall disclose to the BH I/DD Tailored Plan Contractor's trade name (d/b/a) or any other name Contractor may use to perform the duties and obligations under this Contract.
- C. Contractor, on behalf of itself, its affiliates, subsidiaries, heirs, successors, assigns, partners, directors, members, managers, agents, representatives, employees, shall report to the BH I/DD Tailored Plan any sanctions under the Medicare or Medicaid Programs, including but not limited to overpayments, recoupments, fines, paybacks, suspensions, terminations, lawsuits, insurance claims or payouts, as well as any adverse actions by federal or state regulatory agencies within the previous five (5) years.
- D. Contractor's Licensed Practitioners and Licensed Practitioner Associates may be reimbursed for services to Members upon approval of the practitioner's credentials retroactive to the date of receipt of a complete and accurate Contractor application.
- E. To the extent any of the above required disclosure information is captured in current or existing Medicare or NC Medicaid enrollment application documentation, the BH I/DD Tailored Plan shall accept electronic or paper copies of such documentation as meeting this requirement. Entities no longer enrolled in Medicaid or Medicare will be required to independently meet all disclosure requirements of this Paragraph, federal and state laws, rules and regulations, and the BH I/DD Tailored Plan accrediting body.

2. DELIVERY OF SERVICES.

Contractor warrants and represents that it consists of licensed practitioners providing outpatient services in the areas of Psychiatry, Psychology, and/or Social Work.

3. CARE COORDINATION.

- A. Contractor shall allow BH I/DD Tailored Plan Care Management staff direct access to Members served under this Contract. With advance notice and consistent with the BH I/DD Tailored Plan's responsibility to provide care coordination to Members with special healthcare needs, Contractor shall allow designated BH I/DD Tailored Plan Care Management staff to attend any treatment team and discharge planning meetings regarding Members served under this Contract.
- B. For purposes of this contract, discharge is considered termination of service by the Contractor. The Contractor shall notify the BH I/DD Tailored Plan of termination of service within 7 days of the termination. The Contractor will work with the BH I/DD Tailored Plan on coordination of care for any continuing services when necessary. Contractor shall provide information pertinent to the development of an Individual Service Plan (ISP) for persons with Intellectual or other Developmental Disabilities, and a Person Centered Plan (PCP) for persons with Mental Health or Substance Abuse Disorder or shall directly participate in the planning process.
- C. Contractor shall be responsible for the development of treatment and/or supports strategies to address assigned areas of responsibility from the PCP or ISP.
- D. It is the Contractor's responsibility to verify the Member's Medicaid coverage prior to submitting claims to the BH I/DD Tailored Plan. If an individual presents for services who is not eligible for Medicaid and the Contractor reasonably believes that the individual meets Medicaid financial

eligibility requirements, Contractor shall refer the Individual to the Department of Social Services to apply for Medicaid.

4. INSURANCE.

- A. Contractor shall purchase and maintain insurance as described in the Contract and listed below from a company which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance as specified below, unless waived in writing by the BH I/DD Tailored Plan.
 - i. Tail Coverage: Liability insurance may be on either an occurrence basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) for a period of not less than three (3) years after the end of the contract term, or a Contract to continue liability coverage with a retroactive date on or before the beginning of the contract term, shall also be provided.
- B. Contractor shall provide evidence to the BH I/DD Tailored Plan of continual coverage at the levels stated within the Contract and above within seven (7) calendar days if Contractor changes insurance carriers during the performance period of the Contract including tail coverage as required for continual coverage.

Contractor: Legally Authorized Representative

APPENDIX F: HOSPITAL

CONTRACTOR NAME

1. WAIVER OF SOVEREIGN IMMUNITY.

BH I/DD Tailored Plan, only in the manner and to the extent permitted by North Carolina law, including but not limited to N.C.G.S. 122C-152 and N.C.G.S. 122C-210.1, waives the defense of sovereign immunity as to both suit and liability as to all claims and counterclaims between the parties arising from this Contract. This provision shall continue following termination of this Contract for any reason.

2. LICENSES, ACCREDITATIONS, CREDENTIALING AND QUALIFICATIONS.

Facilities and/or Programs that are accredited by accrediting agencies accepted by the Centers for Medicare and Medicaid Services shall be considered in compliance with Quality Assurance/ Quality Improvement requirements. Contractor, upon written request by the BH I/DD Tailored Plan shall provide a copy of its QA/QI Plan. Contractor shall meet all Certificate of Need requirements and further agrees and understands that rates are based on a midnight census.

3. DOCUMENT REQUESTS.

The Contractor shall provide the BH I/DD Tailored Plan with all necessary clinical information for the BH I/DD Tailored Plan's utilization management process. Contractor shall provide specifically denominated clinical or encounter information required by the BH I/DD Tailored Plan to meet State and Federal monitoring requirements within thirty (30) days of the request, except that BH I/DD Tailored Plan may grant additional time to respond for good cause shown and depending upon the size and scope of the request.

4. REFERRAL STATUS.

Acceptance of referrals for inpatient admission is contingent upon the approval and signed order of a physician authorized to admit Enrollees to the inpatient unit.

5. OBLIGATION TO SERVE.

Contractor shall serve only those Members for which it has capacity or staff appropriate to treat the Member at the time the Member presents for treatment.

6. SUBMISSION OF CLAIMS.

Contractor may submit claims subsequent to the 180 day limits in certain instances, for good cause shown and agreed to by the BH I/DD Tailored Plan.

7. AUTHORIZATION OF SERVICES.

In those cases, for services requiring prior authorization for inpatient hospitalization, BH I/DD Tailored Plan shall issue a decision to approve or deny a service within seventy two (72) hours after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:

- i. The Member requests the extension; or
- ii. The Contractor requests the extension; and,
- iii. The BH I/DD Tailored Plan justifies to the Department upon request:
 - a) A need for additional information; and

b) How the extension is in the Member's interest.

8. THIRD PARTY REIMBURSEMENT-INSURANCE & MEDICARE.

If Member has third party insurance and/or Medicare, Contractor shall bill the Member's third party insurance and/or Medicare prior to billing BH I/DD Tailored Plan. Third party insurance and/or Medicare reimbursement or denial information must be indicated on the claim submitted to the BH I/DD Tailored Plan. Claims submitted without third party insurance or Medicare information will be denied.

9. PHYSICIAN BILLING.

All hospital billing by any physician is covered by the BH I/DD Tailored Plan in the following settings: Emergency Department, Inpatient, and Outpatient.

10. ADDITIONAL CONTROLLING AUTHORITY.

In addition to the Controlling Authority specified in the General Terms and Conditions, Contractor understands and agrees that this Contract shall be governed by Chapter 131E of the North Carolina General Statutes, including any subsequent revisions or amendments there.

11. FOLLOW UP AFTER DISCHARGE.

Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care. Discharge planning begins at admission. Effective discharge planning must include collaboration with the family, caregiver or legally responsible person, their informal and natural supports and the PIHP, as well as other agencies involved (such as schools, Social Services, Juvenile Justice, other treatment providers) as appropriate. For a member who is engaged in receiving services from another community-based provider, the Contractor must involve the community-based provider in treatment, discharge planning, and schedule an aftercare appointment within 1-7 days of discharge.

Contractor: Legally Authorized Representative

**APPENDIX F: INTERMEDIATE CARE FACILITY ADDENDUM
FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES**

CONTRACTOR NAME

1. DEFINITIONS.

“Enrollee or Member” means an individual for whom BH I/DD Tailored Plan has issued an authorization for the provision by Contractor of ICF/IID services, as defined by 42 C.F.R. §440.150, during his or her period of residency in (including therapeutic leave days from) a licensed and certified ICF/IID facility operated by Contractor. Such individual shall be considered to be a “Enrollee or Member” only for so long as both such authorization and residency (including therapeutic leave days) is in effect.

2. CONTROLLING AUTHORITY.

In addition to the Controlling Authority listed in the General Terms and Conditions of the Contract, Contractor and BH I/DD Tailored Plan acknowledge that Contractor is in the business of operating one or more licensed and certified intermediate care facilities for individuals with intellectual disabilities (“ICF/IIDs”), each of which have been issued certificate(s) of need (“CONs”) by the State of North Carolina and that such ICF/IID services are to be provided consistent with the Controlling Authorities for such facilities, including but not limited to: 42 C.F.R. §483, Subpart I, federal Guidance to Surveyors: Intermediate Care Facilities for Persons with Mental Retardation [Centers for Medicare and Medicaid Services, State Operations Manual (IOM Publication 100-7, Appendix J)], the North Carolina Certificate of Need (“CON”) Law (N.C.G.S. Chapter 131E, Article 9), and the rules of the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services administered by the Mental Health Licensure and Certification Section of the Division of Health Services Regulation of the North Carolina Department of Health (the “Section”). In the event of any conflicts between or among the above referenced Authorities, it is understood and agreed that the requirements of the federal government shall be controlling.

3. BILLING AUDITS, DOCUMENTATION AND RECORDS RETENTION.

Contractor shall be responsible for completion of all necessary and customary documentation required for the services provided under the Contract, including but not limited to the Member’s Comprehensive Functional Assessment [as required by 42 C.F.R. §483.440(c)(3)] and Individual Program Plan [as required by 42 C.F.R. §483.440(c)].

4. AUTHORIZATION OF SERVICES.

Contractor shall complete and submit to BH I/DD Tailored Plan, for services provided under this contract, documentation of the standardized prior approval process for each Member to be served hereunder utilizing the level of care determination form as designated by the Department. Such documentation shall be provided by Contractor to BH I/DD Tailored Plan every one hundred and eighty (180) days for continued authorization of services.

5. SURVEYS.

The ICF/MR Branch of the North Carolina Division of Health Services Regulation shall be responsible for conducting all surveys of Contractor’s ICF/IID facilities.

6. REIMBURSEMENT.

Contractor shall be reimbursed for authorized ICF/IID level of care provided to each Member on a bed day rate equal to the facility-specific bed day rate as established by the North Carolina Division of Medical Assistance for the current fiscal year.

Contractor and BH I/DD Tailored Plan may create Member-specific rates to address unique needs of an individual Member.

Contractor agrees to accept the payment at the rate established in this paragraph less any applicable Patient Liability, as payment in full from BH I/DD Tailored Plan (but the Member shall remain responsible for the Patient Liability).

Contractor shall submit its approved rate letter from the North Carolina Division of Medical Assistance to BH I/DD Tailored Plan within ten (10) days of receipt.

7. REFERRALS TO CONTRACTOR.

BH I/DD Tailored Plan shall refer appropriate individuals to Contractor for services based on medical necessity, Member acuity, life and safety considerations and behavioral characteristics and the person's individual choice. All referred individuals shall be those for whom a community ICF/IID placement is appropriate, as determined by the individual's treatment team and with the individual's/guardian's acceptance of the placement. BH I/DD Tailored Plan reserves the right to refer to other providers and no referrals or authorizations are guaranteed to take place under this Contract. BH I/DD Tailored Plan shall endeavor at all times to ensure that vacant beds are appropriately filled within five (5) business days of the notification of the vacant bed.

In the event Contractor determines that any referral is not appropriate, BH I/DD Tailored Plan and Contractor shall mediate their differences regarding the referral on an informal basis within 5 business days of such referral. If mediation fails to resolve the issue the decision of the Contractor will be final.

8. PATIENT LIABILITY.

Contractor shall report the Member's Patient Liability to BH I/DD Tailored Plan on a monthly basis. The Patient Liability shall be reported in Box 55 of the 837I (HCFA1450-UB92). Payments to Contractor from BH I/DD Tailored Plan shall be reduced by the amount reported as Patient Liability.

Contractor: Legally Authorized Representative

**APPENDIX G: NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUSINESS ASSOCIATE AGREEMENT**

1. BACKGROUND.

Covered Entity and Business Associate are parties to a contract entitled “Procurement Contract for Provision of Services between Trillium Health Resources (BH I/DD Tailored Plan) and **Contractor Name** a Provider of BH I/DD Tailored Plan Services” (the “Contract”), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

- A. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the “Department”) that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.
- B. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a “business associate” within the meaning of the HIPAA Privacy Rule.
- C. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS.

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Contract:

- A. “Electronic Protected Health Information” shall have the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103.
- B. “HIPAA” means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
- C. “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
- D. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.
- E. “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- F. “Required By Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
- G. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.
- H. Unless otherwise defined in this Contract, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE.

- A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Contract or as required by law.
- B. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Contract.
- C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Contract.

- D. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Contract of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
- E. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and § 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
- F. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
- G. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
- H. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- I. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528,

4. PERMITTED USES AND DISCLOSURES.

- A. Except as otherwise limited in this Contract or by other applicable law or Contract, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
 - i. would not violate the Privacy Rule if done by Covered Entity; or
 - ii. would not violate the minimum necessary policies and procedures of the Covered Entity.
- B. Except as otherwise limited in this Contract or by other applicable law or Contracts, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
 - i. the disclosures are Required By Law; or
 - ii. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- C. Except as otherwise limited in this Contract or by other applicable law or Contracts, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
- D. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or Contracts.

5. TERM AND TERMINATION.

- A. **Term.** This Contract shall be effective as of the effective date stated above and shall terminate when the Contract terminates.
- B. **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
 - i. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Contract and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
 - ii. Immediately terminate this Contract and services provided by Business Associate, to the extent permissible by law; or
 - iii. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

C. Effect of Termination.

- i. Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or Contracts, upon termination of this Contract and services provided by Business Associate, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
- ii. In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. GENERAL TERMS AND CONDITIONS.

- A. This Contract amends and is part of the Contract.
- B. Except as provided in this Contract, all terms and conditions of the Contract shall remain in force and shall apply to this Contract as if set forth fully herein.
- C. In the event of a conflict in terms between this Contract and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.
- D. A breach of this Contract by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

Contractor: Legally Authorized Representative

ATTACHMENT A: CONTRACTED SERVICES AND APPROVED SITES

CONTRACTOR NAME

This document serves as the Attachment A that is referenced in the Contract.

Contractor shall provide services under this Contract at only the sites approved by the BH I/DD Tailored Plan. Rates will be paid in accordance to the Rate Schedule posted on Trillium Health Resources' Website.

Contracted services are continuously updated. To review, verify, and print the services approved under this Contract in real time, Contractor may do the following:

1. Sign in to Provider Direct at <https://www.ciecbh.org/ProviderDirect/Provider/SiteSearch>;
2. Select "Admin"; and
3. Select "Provider Management" in the top right side of the screen.

Provider Management displays the Master Site on the top of the list and each contracted sub-site will follow.

- To review every service that is currently in the Contract, select the Master Site.
- To review services that are site specific, select the sub-site.

If preferred, the Contractor may request a copy of the contracted services and service sites that are approved from the BH I/DD Tailored plan at any time.

Contractor: Legally Authorized Representative

ATTACHMENT B: DEFICIT REDUCTION ACT

1. OVERVIEW.

Effective January 1, 2007, the Deficit Reduction Act (DRA) of 2005 required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below and in summary, it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall

- A. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);
- B. Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
- C. Include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to be in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program. As a North Carolina Medicaid provider, or the owner/operator/manager of a North Carolina Medicaid provider entity, Contractor understands and complies with the above requirements and if applicable has detailed provisions regarding policies and procedures for detecting and preventing fraud, waste, and abuse; and Contractors employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste, and abuse.

Contractor maintains a copy of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance.

Contractor: Legally Authorized Representative

ATTACHMENT C: ADVANCED MEDICAL HOME PROGRAM POLICY FOR MEDICAID AND NC HEALTH CHOICE MEMBERS

1. BACKGROUND.

- A. The Advanced Medical Home (AMH) program refers to an initiative under which a Standard Plan or BH I/DD Tailored Plan must pay Medical Home Fees to all participating primary care practices that act as PCPs. In the context of BH I/DD Tailored Plans, only AMH practices certified as AMH+ practices will play the lead role in providing Tailored Care Management. However, BH I/DD Tailored Plans must include the standard terms and conditions below in contracts with all practices participating in the AMH program and must pay Medical Home Fees as set out in *Section V.B.4.v(xvii) Payments of Medical Home Fees to Advanced Medical Homes*.
- B. An AMH “practice” will be defined by an NPI and service location.

2. Standard Terms and Conditions for BH I/DD Tailored Plan Contracts with All Advanced Medical Home Providers

1. Accept members and be listed as a PCP in the BH I/DD Tailored Plan’s member-facing materials for the purpose of providing care to members and managing their healthcare needs.
2. Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.
3. Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
4. Provide direct patient care a minimum of thirty (30) office hours per week.
5. Provide preventive services, in accordance with *Section VII. Fourth Revised and Restated Attachment M.2. Table 1: Required Preventive Services*.
6. Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan’s medical record documentation guidelines.
7. Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
8. Transfer copies of the member’s medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.
9. Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan’s network adequacy standards.
10. Refer for a second opinion as requested by the member, based on Department guidelines and BH I/DD Tailored Plan standards.
11. Review and use member utilization and cost reports provided by the BH I/DD Tailored Plan for the purpose of AMH-level UM and advise the BH I/DD Tailored Plan of errors, omissions or discrepancies if they are discovered.
12. Review and use the monthly enrollment report provided by the BH I/DD Tailored Plan for the purpose of participating in BH I/DD Tailored Plan or practice-based population health or care management activities.

Reference Number	AMH Preventative Health Requirement	0 to 5	6 to 21	22 to 121
1	Adult Preventative and Ancillary Health Assessment			Y
2	Blood Lead Level Screening	*		
3	Cervical Cancer Screening (applicable to females only)		As Needed	
4	Vaccines per ACIP recommendation ACIP Vaccine Recommendations I CDC	Y	Y	Y
5	Reserved.			
6	Health Check Screening Assessment	*	*	
7	Hearing	*	*	
8 & 9	Hemoglobin or Hematocrit	*	*	As Needed
10	Reserved.			
11	Reserved.			
12	Reserved.			
13	Reserved.			
14	Reserved.			
15	Standardized Written Developmental	*		
16	Reserved.			
17	Tuberculin Testing (PPD Intradermal injection/Mantoux Method)	*	*	Y
18	Urinalysis		*	Y
19	Reserved.			
20	Vision Assessment	*	*	Y

*Please refer to the American Academy of Pediatrics: Bright Futures Periodicity Schedule for information on when preventive services should be delivered to children under the age of 21. The AAP Bright Futures Periodicity Schedule can be found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Contractor: Legally Authorized Representative

**ATTACHMENT D: PREGNANCY MANAGEMENT PROGRAM POLICY
FOR MEDICAID AND NC HEALTH CHOICE MEMBERS**

1. BACKGROUND.

- A. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among participating providers.

2. SCOPE.

- A. The scope of this Policy covers the requirements that must be in Contracts between the BH I/DD Tailored Plan and providers who offer prenatal, perinatal and postpartum services and thus are part of the Pregnancy Management Program outlined below.

3. PREGNANCY MANAGEMENT PROGRAM REQUIREMENTS.

- A. The BH I/DD Tailored Plan shall incorporate the following requirements for providers of the Pregnancy Management Program into their contracts with all providers of prenatal, perinatal and postpartum care:
- i. Complete the standardized risk-screening tool at each initial visit.
 - ii. Allow the BH I/DD Tailored Plan or the BH I/DD Tailored Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
 - iii. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
 - iv. Commit to decreasing the cesarean section rate among nulliparous women.
 - v. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
 - vi. Complete a high-risk screening on each pregnant BH I/DD Tailored Plan member in the program and integrate the plan of care with Tailored Care Management and/or Care Management for High-Risk Pregnancy.
 - vii. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty (20) percent).
 - viii. Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.
- B. Require that BH I/DD Tailored Plan network providers send, within one (1) Business Day of the provider completing the screening, all screening information and applicable medical record information for members in care management for high-risk pregnancies to the applicable BH I/DD Tailored Plans, AMH+ practices or CMAs (as applicable), and the LHDs that are contracted for the provision of providing care management services for high-risk pregnancy.

Contractor: Legally Authorized Representative

ATTACHMENT E: CARE MANAGEMENT FOR HIGH-RISK PREGNANCY POLICY FOR MEDICAID

1. BACKGROUND.

- A. “Care Management for High-Risk Pregnancy” refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs).
- B. For Contract Year 1, LHDs shall have “right of first refusal” as contracted providers of Care Management for High-Risk Pregnant Women. Women participating in Care Management for High-Risk Pregnant Women with an LHD are also eligible for Tailored Care Management (i.e., a second care manager) to address other needs that are not included in the LHD model.
- C. After Contract Year 2, Care Management for High-Risk Pregnancy shall be fully subsumed into the Tailored Care Management model.

2. SCOPE.

- A. The scope of this Policy covers the agreement between the BH I/DD Tailored Plan and LHD providers offering Care Management for High-Risk Pregnancy, as outlined below and in the Contract.

3. GENERAL CONTRACTING REQUIREMENT.

- A. LHD shall accept referrals from the BH I/DD Tailored Plan for Care Management for High-Risk Pregnancy services.

4. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: OUTREACH.

- A. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.
- B. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in care management.

5. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: POPULATION IDENTIFICATION AND ENGAGEMENT.

- A. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) Calendar Days of receipt of risk screening forms.
- B. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.
- C. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.
- D. LHD shall review available BH I/DD Tailored Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.
- E. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

6. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: ASSESSMENT AND RISK STRATIFICATION.

- A. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority

risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support.

- B. LHD shall utilize assessment findings, including those conducted by the BH I/DD Tailored Plan, to determine level of need for care management support.
- C. LHD shall document assessment findings in the care management documentation system.
- D. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.
- E. LHD shall assign case status based on level of patient need.

7. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: INTERVENTIONS.

- A. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and/or other interventions needed to achieve Care Plan goals.
- B. LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.
- C. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.
- D. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.
- E. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the member's BH I/DD Tailored Plan Network.
- F. LHD shall document all care management activity in the care management documentation system.

8. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: INTEGRATION WITH THE BH I/DD TAILORED PLAN AND HEALTH CARE PROVIDERS.

- A. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.
- B. LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.
- C. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice in the county or serving residents of the county.
- D. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.
- E. LHD shall ensure awareness of BH I/DD Tailored Plan members' "in network" status with providers when organizing referrals.
- F. LHD shall ensure understanding of the BH I/DD Tailored Plan's prior authorization processes relevant to referrals.

9. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: COLLABORATION WITH BH I/DD TAILORED PLAN.

- A. LHD shall work with the BH I/DD Tailored Plan to ensure program goals are met.
- B. LHD shall review and monitor BH I/DD Tailored Plan reports created for the Pregnancy Management Program and Care Management for High-Risk Pregnancy services to identify individuals at greatest risk.
- C. LHD shall communicate with the BH I/DD Tailored Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.
- D. LHD shall participate in pregnancy care management and other relevant meetings hosted by the BH I/DD Tailored Plan.

10. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: TRAINING.

- A. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by the BH I/DD Tailored Plan and/or the Department, including webinars, new hire orientation or other programmatic training.
- B. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the BH I/DD Tailored Plan and/or the Department.
- C. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
- D. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and trauma-informed care techniques on an ongoing basis.

11. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: STAFFING.

- A. LHD shall employ care managers meeting pregnancy care management competencies, defined as having at least one of the following qualifications:
 - i. Registered nurses
 - ii. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
 - iii. Reserved.
 - iv. Bachelor's degree in human service field with five (5) or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children aged 0-5.
 - v. Bachelor's degree in human service field with three (3) or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children aged 0-5 and has certification as a Case Manager (Commission for Case Manager (CCM) Certification preferred).
 - vi. Program staff hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. The grandfathered status does not transfer to any other position.
 - vii. Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a Bachelor's or Master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.
- B. LHD shall ensure that Community Health workers for Care Management for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
- C. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.
- D. If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
- E. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
- F. LHD shall ensure that pregnancy care managers demonstrate:
 - i. Proficiency with the technologies required to perform care management functions
 - ii. Motivational interviewing skills and knowledge of adult teaching and learning principles
 - iii. Ability to effectively communicate with families and providers
 - iv. Critical thinking skills, clinical judgment and problem-solving abilities
- G. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
 - i. Provision of program updates to care managers

- ii. Daily availability for case consultation and caseload oversight
 - iii. Regular meetings with direct service care management staff
 - iv. Utilization of reports to actively assess individual care manager performance
 - v. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual
- H. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following BH I/DD Tailored Plan/Department guidance about communication with the BH I/DD Tailored Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
- i. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the BH I/DD Tailored Plan.

Contractor: Legally Authorized Representative

**ATTACHMENT F: CARE MANAGEMENT FOR AT-RISK CHILDREN POLICY
FOR MEDICAID AND NC HEALTH CHOICE MEMBERS**

1. BACKGROUND.

- A. Care Management for At-Risk Children are care management services provided by Local Health Departments (LHD) to a subset of the Medicaid population ages zero (0) to five (5) identified as being “high risk.”
- B. For Contract Year 1, LHDs shall have the right of first refusal to conduct Care Management for At-Risk Children for BH I/DD Tailored Plan-eligible children ages zero (0) to five (5) who are already enrolled in Care Management for At-Risk Children at the time of BH I/DD Tailored Plan launch. Children enrolled in Care Management for At-Risk Children will not be eligible for Tailored Care Management while enrolled in Care Management for At-Risk Children because the two programs provide duplicative services.
- C. After the launch of BH I/DD Tailored Plans, children covered by BH I/DD Tailored Plans who would otherwise have become eligible for Care Management for At-Risk Children will be enrolled into Tailored Care Management and not into Care Management for At-Risk Children.
- D. After Contract Year 1, Care Management for At-Risk Children shall be fully subsumed into the Tailored Care Management model.

2. SCOPE.

- A. The scope of this Policy covers the required terms that must be included in Contracts between the BH I/DD Tailored Plan and LHD providers offering Care Management for At-Risk Children outlined below and in the Contract.

3. CARE MANAGEMENT FOR AT-RISK CHILDREN: GENERAL REQUIREMENTS.

- A. LHD shall collaborate with out-of-county organizations providing Tailored Care Management— AMH+ practices, CMAs, and BH I/DD Tailored Plans—to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.
- B. LHD shall identify or develop, if necessary, a list of community resources available to meet the specific needs of the population.
- C. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.

4. CARE MANAGEMENT FOR AT-RISK CHILDREN: FAMILY ENGAGEMENT

- A. LHD shall involve families (or a legal guardian, when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
- B. LHD shall foster self-management skill building when working with families of children.
- C. LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

5. CARE MANAGEMENT FOR AT-RISK CHILDREN: ASSESSMENT AND STRATIFICATION OF CARE MANAGEMENT SERVICE LEVEL.

- A. LHD shall review and monitor BH I/DD Tailored Plan reports created for Care Management for At-Risk Children, along with the information obtained from the family, to ensure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.
- B. LHD shall use the information gained from the assessment to determine the need for services and the level of service to be provided.

6. CARE MANAGEMENT FOR AT-RISK CHILDREN: PLAN OF CARE.

- A. LHD shall provide information and/or education to meet families’ needs and encourage self-management using materials that meet literacy standards.
- B. LHD shall ensure children/families are well linked to the child’s PCP.

- C. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving Care Plan goals.
- D. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child and use any locally developed resource list (including NCCARE360) to ensure families are well linked to resources to meet the identified need.
- E. LHD shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

7. CARE MANAGEMENT FOR AT-RISK CHILDREN: INTEGRATION WITH BH I/DD TAILORED PLANS AND HEALTH PROVIDERS.

- A. LHD shall collaborate with the member's PCP to facilitate implementation of patient-centered plans and goals targeted to meet individual children's needs.
- B. LHD shall ensure that changes in the care management level of care or in the need for patient support and follow-up and other relevant updates (especially during periods of transition) are communicated to the PCP and to the BH I/DD Tailored Plan.
- C. LHD shall ensure awareness of BH I/DD Tailored Plan members' "in network" status with providers when organizing referrals.
- D. LHD shall ensure understanding of BH I/DD Tailored Plans' prior authorization processes relevant to referrals.

8. CARE MANAGEMENT FOR AT-RISK CHILDREN: SERVICE PROVISION.

- A. LHD shall document all care management activities in the care management documentation system in a timely manner.
- B. LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and shall work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

9. CARE MANAGEMENT FOR AT-RISK CHILDREN: TRAINING.

- A. LHD shall participate in Department or BH I/DD Tailored Plan-sponsored webinars, trainings and continuing education opportunities as provided.
- B. LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high-risk children.

10. CARE MANAGEMENT FOR AT-RISK CHILDREN: STAFFING.

- A. LHD shall hire care managers who meet Care Management for At-Risk Children care coordination competencies and have at least one of the following qualifications:
 - i. Registered nurses
 - ii. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
 - a) Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as social workers under the Office of State Personnel guidelines.
- B. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.
- C. LHD shall ensure that Care Management for At-Risk Children care managers demonstrate:
 - i. Proficiency with the technologies required to perform care management functions— particularly as pertains to claims data review and the care management documentation system
 - ii. Ability to effectively communicate with families and providers
 - iii. Critical thinking skills, clinical judgment and problem-solving abilities

- iv. Motivational interviewing skills, knowledge of trauma-informed care, and knowledge of adult teaching and learning principles
- D. LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.
- E. If the LHD has only a single Care Management for At-Risk Children care manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
- F. LHD shall maintain services during the event of an extended vacancy.
- G. In the event of an extended vacancy, LHD shall complete and submit a vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.
- H. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight.
- I. LHD shall ensure that community health workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children care manager.
- J. LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
 - i. Provision of program updates to care managers
 - ii. Daily availability for case consultation and caseload oversight
 - iii. Regular meetings with direct service care management staff
 - iv. Utilization of monthly and on-demand reports to actively assess individual care manager performance
- K. LHD shall ensure that supervisors who carry a caseload also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

Contractor: Legally Authorized Representative

ATTACHMENT G: INDIAN HEALTH CARE PROVIDERS

The BH I/DD Tailored Plan shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. PURPOSE OF ADDENDUM; SUPERSESSION.

The purpose of this BH I/DD Tailored Plan Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs Contract by and between Trillium Health Resources (herein "BH I/DD Tailored Plan") and CONTRACTOR (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the BH I/DD Tailored Plan's network IHCP Contract or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. DEFINITIONS.

For purposes of this Addendum, the following terms and definitions shall apply:

- a. "Indian" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:
 - i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree of any such member;
 - ii. Is an Eskimo or Aleut or other Alaska Native;
 - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;
 - iv. Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

- b. "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
- c. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid Managed Care contract.
- d. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661.
- e. "Indian tribe" has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).
- f. "Tribal health program" has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).
- g. "Tribal organization" has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).
- h. "Urban Indian organization" has the meaning given in the IHCA Section 4(29), 25 U.S.C. § 1603(29).

3. DESCRIPTION OF IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

- IHS.
- An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.
- A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

¹ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

- A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).
- An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCA.

4. COST SHARING EXEMPTION FOR INDIANS; NO REDUCTION IN PAYMENTS.

- a. The BH I/DD Tailored Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.
- b. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. MEMBER OPTION TO SELECT THE IHCP AS PRIMARY HEALTH CARE IHCP.

The BH I/DD Tailored Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the BH I/DD Tailored Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. § 438.14(b)(3) and 457.1209.

6. CONTRACT TO PAY IHCP.

- a. The BH I/DD Tailored Plan shall pay the IHCP for covered Medicaid Managed Care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.
- b. The State shall make a supplemental payment to the IHCP to make up the difference between the amount the BH I/DD Tailored Plan pays and the amount the IHCP would have received under FFS or the applicable encounter rate published annually by the IHS if the amount the IHCP receives from the BH I/DD Tailored Plan is less than the amount they would have received under FFS or the applicable encounter rate.

7. PERSONS ELIGIBLE FOR ITEMS AND SERVICES FROM IHCP.

- a. Nothing in this Contract shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.
- b. No term or condition of the BH I/DD Tailored Plan's network IHCP Contract or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The BH I/DD Tailored Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. APPLICABILITY OF FEDERAL LAWS NOT GENERALLY APPLICABLE TO OTHER PROVIDERS.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving BH I/DD Tailored Plan members. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

9. NON-TAXABLE ENTITY.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a BH I/DD Tailored Plan to collect or remit any federal, state, or local tax.

¹ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

10. INSURANCE AND INDEMNIFICATION.

- a. Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the BH I/DD Tailored Plan network provider Contract (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.
- b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the BH I/DD Tailored Plan network provider Contract (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.
- c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the BH I/DD Tailored Plan network provider Contract or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. LICENSURE AND ACCREDITATION.

Pursuant to 25 USC §§ 1621t and 1647a, the BH I/DD Tailored Plan shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the BH I/DD Tailored Plan shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. DISPUTE RESOLUTION.

In the event of any dispute arising under the BH I/DD Tailored Plan's network IHCP Contract or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the BH I/DD Tailored Plan's network Contract, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. GOVERNING LAW.

The BH I/DD Tailored Plan's network IHCP Contract and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such Contract and all addenda thereto and federal law, federal law shall prevail.

Nothing in the BH I/DD Tailored Plan's network IHCP Contract or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

¹ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

14. MEDICAL QUALITY ASSURANCE REQUIREMENTS.

To the extent the BH I/DD Tailored Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

15. CLAIMS FORMAT.

The BH I/DD Tailored Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. PAYMENT OF CLAIMS.

The BH I/DD Tailored Plan shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c)(2) and 457.1209 and shall pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. HOURS AND DAYS OF SERVICE.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the BH I/DD Tailored Plan as to its hours and days of service. At the request of the BH I/DD Tailored Plan, such IHCP shall provide written notification of its hours and days of service.

18. COORDINATION OF CARE/REFERRAL REQUIREMENTS.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the BH I/DD Tailored Plan.

19. SOVEREIGN IMMUNITY.

Nothing in the BH I/DD Tailored Plan's network IHCP Contract or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. ENDORSEMENT.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the BH I/DD Tailored Plan.

APPROVALS

For the BH I/DD Tailored Plan:

Date:

Signature:

For the IHCP:

Date:

Signature:

¹ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS as an IHCP:

1. Anti-Deficiency Act, 31 U.S.C. § 1341;
2. ISDEAA, 25 U.S.C. § 450 et seq.;
3. Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
4. Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5. Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
6. IHCA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:

1. ISDEAA, 25 U.S.C. § 450 et seq.;
2. IHCA, 25 U.S.C. § 1601 et seq.;
3. FTCA, 28 U.S.C. §§ 2671-2680;
4. Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5. Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
6. HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:

1. IHCA, 25 U.S.C. § 1601 et seq.
2. Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
3. HIPAA, 45 C.F.R. Parts 160 and 164.

Contractor: Legally Authorized Representative

¹ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

Signature Page Between:
TRILLIUM HEALTH RESOURCES (BH I/DD TAILORED PLAN)
And
CONTRACTOR NAME

IN WITNESS WHEREOF:

IN WITNESS WHEREOF: Each party has caused this Contract and all applicable attachments and addendums to be executed as the act of said party. Each individual signing below certifies that he or she has been granted the authority to bind the respective party to the terms of this Contract and any Addendums or Attachments thereto.

Joy Futrell, CEO
Trillium Health Resources
TIN: 56-0898928

Authorized Signer
Contractor
TIN:

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Kellie Baker, CFO
Trillium Health Resources