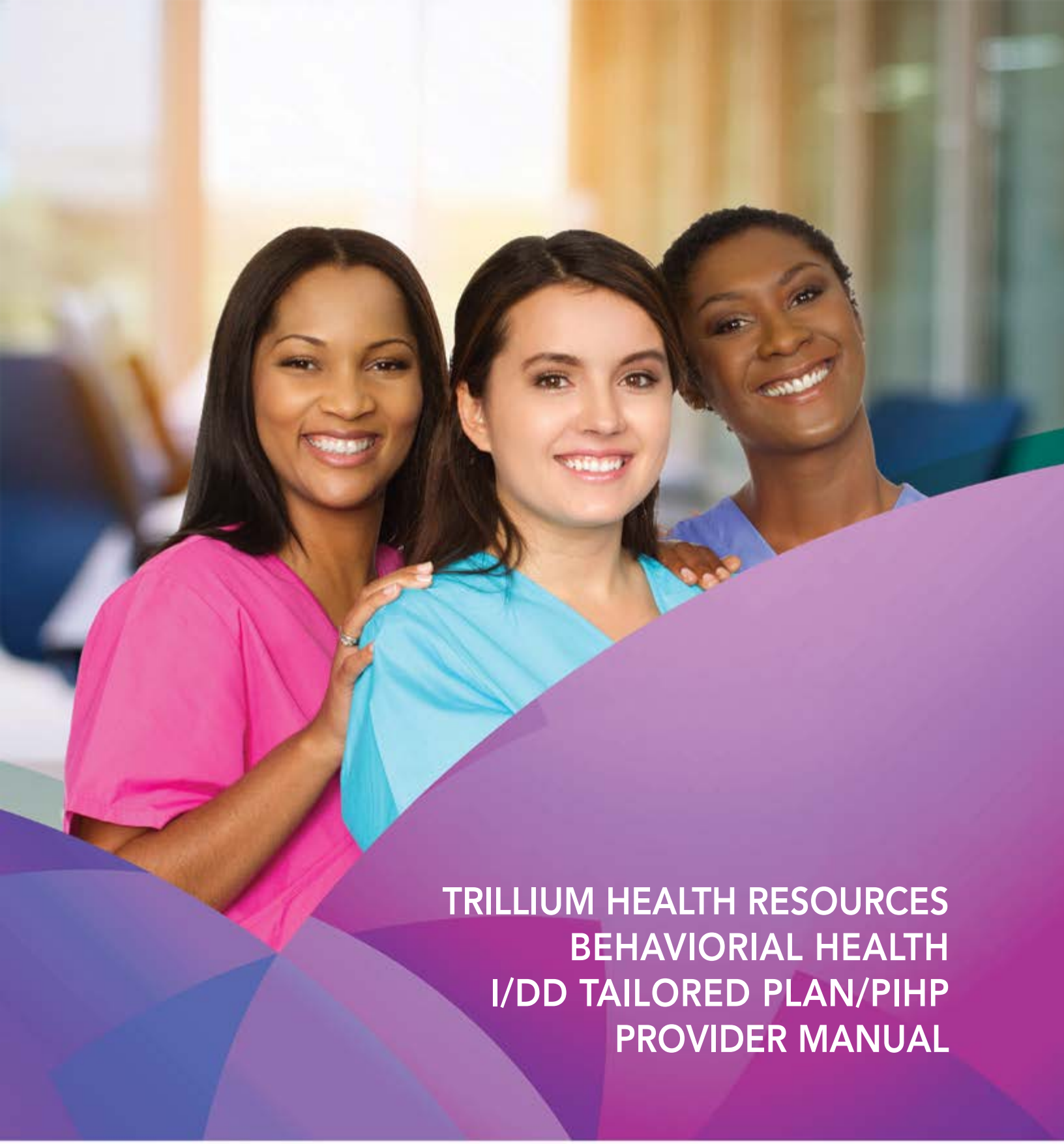


TRILLIUM HEALTH RESOURCES BEHAVIORIAL HEALTH I/DD TAILORED PLAN/PIHP PROVIDER MANUAL

July 1, 2024

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

A. INTRODUCTION

This document is available on the Trillium Health Resources (Trillium) provider portal and website through TrilliumHealthResources.org on the For Providers tab. Please see the Resources & Web Links section at the end of this Manual for more specific webpage links for documents referenced throughout. A printed copy of the information posted on the website is available upon request by calling Trillium at the Provider Support Service Line below.

Trillium keeps the provider network apprised of new information and procedural changes on an ongoing basis to ensure providers are up-to-date and understand revised expectations as they happen. We send timely messages through our email distribution via Constant Contact so please be sure at least one staff person in your office signs up to receive these updates. We will incorporate those changes as necessary and publish revised editions of this Provider Manual. See additional information regarding Provider Manual changes at the end of this document.

TRILLIUM HEALTH RESOURCES

Corporate Headquarters
201 West First St.
Greenville, NC 27858-1132

Member & Recipient Services:
1-877-685-2415

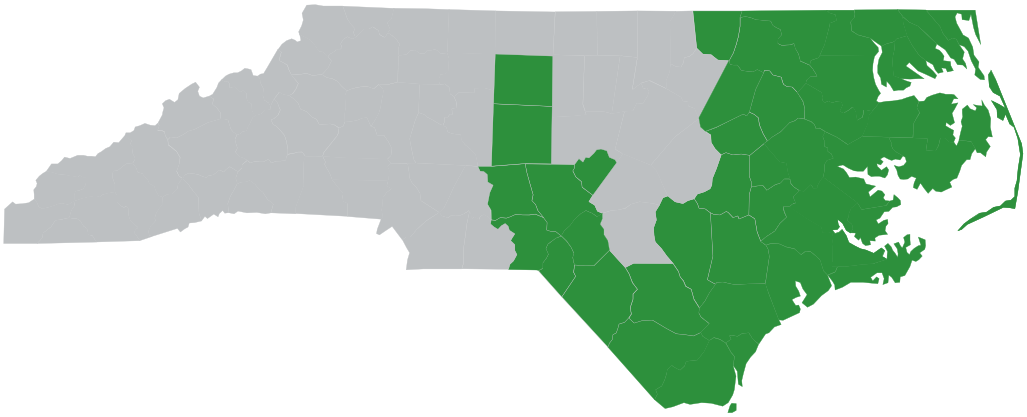
Behavioral Health Crisis Line:
1-888-302-0738

Please note the toll-free Member & Recipient Services number, 1-877-685-2415, is intended for and limited to members and recipient issues around member care.

Provider Support Service Line:
1-855-250-1539

Nurse Line:
1-877-685-2415

Pharmacy Line:
1-866-245-4954



A MESSAGE FROM THE CEO

WELCOME TO THE TRILLIUM HEALTH RESOURCES PROVIDER NETWORK!

We are pleased to have you as a partner. Thank you for helping us fulfill our responsibility to provide people in our 46-county catchment area with timely access to a full array of high quality, medically necessary physical health, serious mental health, intellectual and/or developmental disability, substance use services and traumatic brain injury services. We work together with our partners and community stakeholders to build and strengthen foundations of well-being and help deepen connections between citizens and their neighbors.

Trillium is committed to the principles of recovery and self-determination. We whole-heartedly believe in person-centered services and supports. We fully understand that our success in achieving those goals is dependent upon our provider network. The public behavioral health system is successful, because of the dedicated, local providers who are deeply rooted in our communities.

This Provider Manual outlines how to do business with Trillium. It includes the processes and procedures we expect from you and tells you what you can expect from us in return. This Provider Manual is intended for Trillium's Provider Network of Tailored Plan, Prepaid Inpatient Health Plan and State-Funded providers. It is our intent for this Manual to be a living document that serves as a resource for Trillium staff and our provider network. To that end, we welcome your suggestions for improvement.

JOY FUTRELL

Chief Executive Officer

Trillium Health Resources

Transforming lives and building community well-being through partnership and proven solutions.

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WELCOME TO TRILLIUM!

Your responsibility as a Trillium contracted provider is to be familiar with and adhere to guidelines outlined in this manual. Your adherence to these guidelines will assist Trillium in providing you with timely service authorizations and claims reimbursement. We thank you for your participation in our provider network and look forward to a long and rewarding relationship as we work together to provide responsive treatment to the people we both serve.

TRILLIUM—WHO WE ARE

Trillium is a Behavioral Health and Intellectual/ Developmental Disabilities (BH/IDD) Tailored Plan/ PIHP that manages Medicaid, block grant, state and local funding for severe mental health, intellectual and/ or developmental disabilities, substance use disorder, traumatic brain injury, pharmacy, and physical health services and supports for people living in (—or whose Medicaid eligibility was established in) the counties we serve. Our mission is to transform lives and build community well-being through partnership and proven solutions.

Trillium prioritizes finding the right individualized care for the people we serve. A person's overall well-being is dependent upon so much more than just health care. Where a person physically and socially lives, learns, works, and plays all have a tremendous impact. We take a person-centered, community-based approach to health and well-being.

Trillium is nationally accredited by National Committee for Quality Assurance (NCQA) as a Health Plan. Trillium complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Trillium does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

B. CLINICAL PRACTICE STANDARDS AND UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) Department includes Utilization Review (UR) functions. UM will determine whether a member meets medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services. The UM Program Policies are currently under development and will be included prior to Tailored Plan launch]. Information on the UM Program Policies and the Clinical Practice Guidelines can be found on the Trillium website.

The Trillium Health Resources UM program is designed to ensure that beneficiaries and members of Trillium receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible beneficiaries/

all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, pharmacy, ancillary care services along with mental health, substance use and services for intellectual/developmental disabilities.

The Trillium Health Resources UM program seeks to optimize a beneficiary's health status, sense of well-being, productivity, and access to quality health care while, at the same time, actively managing cost trends. The UM program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

C. COVERED SERVICES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy	YES
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Clinical Coverage Policy 15	YES
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)	YES
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement	YES
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes	YES
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound	YES
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a	YES
Chiropractic Services	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Clinic Services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments	YES
Dietary Evaluation and Counseling and Medical Lactation Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services	YES
Durable Medical Equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics	YES
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members	YES
Family Planning Services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services	YES
Federally Qualified Health Center (FQHC) Services	SSA, Title XIX, Section 1905(a)(2) (C) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Freestanding birth center services (when licensed or otherwise recognized by the State)	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11	YES
Gynecology	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions	YES
Hearing Aids	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services	YES
HIV Case Management Services	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management	YES
Home Health Services	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. §440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.l, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A	YES
Home Infusion Therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy	YES
Hospice Services	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services	YES
ICF-IID Services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Innovations Waiver Services	8P: North Carolina Innovations	YES (Innovations waiver enrollees only)
Inpatient Hospital Services	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. §440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services	YES
Inpatient Psychiatric Services for Individuals under age 21	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Inpatient and Outpatient BH Services (Covered by both Medicaid and NCHC)	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: Mobile Crisis Management Diagnostic Assessment Intensive-In-Home Services Multisystemic Therapy Child and Adolescent Day Treatment Partial Hospitalization Substance Abuse Intensive Outpatient Program Outpatient Opioid Treatment Programs NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-6: Community Support Team (CST) North Carolina Clinical Coverage Policy 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D-2: Residential Treatment Services NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F—Researched Based BH Treatment for Autism Spectrum Disorders NC Clinical Coverage Policy 8G—Peer Supports NC Clinical Coverage Policy 8I—Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH)	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Laboratory and X-ray Services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services	YES
Maternal Support Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow- up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Non-Emergent Transportation to Medical Care	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 Non-Emergency Medical Transportation Managed Care Policy	YES
Nursing Facility Services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40 42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities	YES
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home	YES
Occupational Therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES
Office Based Opioid Treatment (OBOT)	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine- Naloxone	YES
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Optometry Services	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 441.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a xG.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21	YES
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5	YES
Outpatient and Residential BH services (only covered By Medicaid)	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 *NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:* • Psychosocial Rehabilitation • Professional Treatment Services in a Facility Based Crisis System • Substance Abuse Comprehensive Outpatient Treatment Program • Substance Abuse Non-Medical Community Residential Treatment • Substance Abuse Medically Monitored Community Residential Treatment • Ambulatory Detoxification Services • Non-Hospital Medical Detoxification Services • Medically Supervised or Alcohol or Drug Abuse Treatment Center (ADATC) Detoxification • Community Support Team	YES
Outpatient Hospital Services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1	YES
Personal Care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older NC Clinical Coverage Policy 1B, Physician's Drug Program	YES
Physical Therapy	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages7c, 7c.15 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Physician Services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. §440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.l, Page 7h NC Health Choice State Plan, Section 6.2.3 NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Physician services	NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Podiatry Services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care	YES
Prescription Drugs and Medication Management	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters Section V.B.2.iii. Pharmacy Benefits of the Contract	YES
Private Duty Nursing (PDN) Services	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Prosthetics, Orthotics and Supplies	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics	YES
Reconstructive Surgery	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty	YES
Respiratory Care Services	SSA, Title XIX, Section 1905(a)(20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services	YES
Rural Health Clinic (RHC) Services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES		
SERVICE	***KEY REFERENCES[1,2]***	***COVERED BY MEDICAID***
Services for individuals age 65 or older in an Institution for Mental Disease (IMD)	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient BH Services	YES
Speech, Hearing and Language Disorder Services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring	YES
Tobacco Cessation Counseling for Pregnant Women	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Transplants and Related Services	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)	YES

SUMMARY OF MEDICAID COVERED SERVICES & CLINICAL COVERAGE POLICIES

SERVICE	KEY REFERENCES[1,2]	COVERED BY MEDICAID
Transplants and Related Services	NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/ Liver and Multivisceral Transplants	YES
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device	YES
Vision Services	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older	YES

[1] North Carolina's Medicaid State Plan is available here: medicaid.ncdhhs.gov/document/state-plan-undertitle-xix-social-security-act-medical-assistance-program. Medicaid and NC Health Choice clinical coverage policies are available here: medicaid.ncdhhs.gov/providers/clinical-coverage-policies. Note—NC Health Choice is being absorbed under the umbrella of NC Medicaid.

[2] The Department reserves the right to update the clinical coverage policies for covered benefits.

STATE-FUNDED BH, I/DD, AND TBI SERVICES		
Disability Group	***Core Services***	***Non-Core Services***
All—Disability	1. Diagnostic assessment[22] 2. Facility based crisis for adults[23] 3. Inpatient BH services 4. Mobile crisis management 5. Outpatient services[24] 6. Mental health recovery residential services[28] 7. Individual placement and support-supported employment (IPS-SE)[29] 8. Transition management service 9. Critical Time Intervention 10. BH Comprehensive Case Management	1. BH urgent care 2. Facility based crisis for children and adolescents
Child Mental Health	1. High fidelity wraparound (HFW)[30] 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental health day treatment
I/DD and TBI[31]	1. Residential Supports 2. Day Supports Group 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment13 6. Respite 7. Adult Day Vocational Programs (ADVP)	1. TBI long term residential rehabilitation services

STATE-FUNDED BH, I/DD, AND TBI SERVICES		
Disability Group	***Core Services***	***Non-Core Services***
Substance Use Disorder—Adult	1. Ambulatory detoxification 2. Assertive engagement 3. Case management[32] 4. Clinically managed population specific high intensity residential services[33] 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports[34] 8. Substance use residential services and supports[35] 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment) 15. Community Support Team 16. BH Comprehensive Case Management	1. Social setting detoxification services

STATE-FUNDED BH, I/DD, AND TBI SERVICES		
Disability Group	***Core Services***	***Non-Core Services***
Substance Use Disorder—Child	1. Multi-systemic therapy 2. SAIOP 3. Substance use residential services and supports 4. High fidelity wraparound (HFW)[9] 5. Assertive Engagement	1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite
All—Disability	1. Diagnostic assessment[22] 2. Facility based crisis for adults[23] 3. Inpatient BH services 4. Mobile crisis management 5. Outpatient services[24]	1. BH urgent care 2. Facility based crisis for children and adolescents
Adult Mental Health	1. Assertive community treatment (ACT)[25] 2. Assertive engagement 3. Case management[26] 4. Community support team (CST) 5. Peer Support Services[27] 6. Psychosocial rehabilitation 7. Mental health recovery residential services[28] 8. Individual placement and support-supported employment (IPS-SE)[29] 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management	1. Partial hospitalization

STATE-FUNDED BH, I/DD, AND TBI SERVICES		
Disability Group	***Core Services***	***Non-Core Services***
Child Mental Health	1. High fidelity wraparound (HFW)[30] 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental health day treatment
I/DD and TBI[31]	1. Residential Supports 2. Day Supports Group 3. 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment[13] 6. Respite 7. Adult Day Vocational Programs (ADVP)	1. TBI long term residential rehabilitation services
Substance Use Disorder—Adult	1. Ambulatory detoxification 2. Assertive engagement 3. Case management[32] 4. Clinically managed population specific high intensity residential services[33] 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports[34]	1. Social setting detoxification services

[22] Diagnostic assessment may be provided through Telehealth.

[23] This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

[24] The BH I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.

[25] The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients.

[26] This service may include critical time intervention, case management, and resource intensive case management (RICM).

[27] Peer supports include individual and group services.

[28] This category of services may include group living and supervised living among other services.

[29] The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at: store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-Kit/SMA08-4364

[30] The Department intends allocate funding for slots for HFW services.

[31] I/DD and TBI care management will be only be provided by the BH I/DD Tailored Plan.

[32] This service may include critical time intervention, case management, and RICCM.

[33] The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.

[34] Peer supports include individual and group services.

BEHAVIORAL HEALTH, I/DD, AND TBI SERVICES COVERED BY PIHP

- Inpatient BH services
- Outpatient BH emergency room services
- Outpatient BH services provided by direct-enrolled providers
- Psychological services in health departments and school-based health centers sponsored by health departments
- Peer supports
- Partial hospitalization
- Mobile crisis management
- Facility-based crisis services for children and adolescents
- Professional treatment services in facility-based crisis program
- Outpatient opioid treatment
- Ambulatory detoxification
- Research-based BH treatment for autism spectrum disorder (ASD)
- Diagnostic assessment
- Non-hospital medical detoxification
- Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
- Residential treatment facility services
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services
- Psychiatric residential treatment facilities (PRTFs)
- Assertive community treatment (ACT)
- Community support team (CST)[2]
- Psychosocial rehabilitation
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment program (SACOT)
- Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Early and periodic screening, diagnostic and treatment (EPSDT) services
- Supported employment*
- Individual transition and support*
- Respite*
- Community living and supports*
- Community transition*

*North Carolina is currently in the process of developing a State Plan Amendment (SPA) to CMS to cover these services through 1915(i) authority.

[2] CST includes tenancy supports.

CROSSWALK OF COVERED AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) SUD SERVICES TO NORTH CAROLINA MEDICAID COVERED SUD SERVICES		
ASAM Level of Care	***ASAM Service Title***	***North Carolina Medicaid Service Title***
1	Outpatient services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
N/A		Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
4	Medically managed intensive inpatient services	Inpatient BH services
Office-based opioid treatment	Office-based opioid treatment	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment
1-WM	Ambulatory withdrawal management with extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Ambulatory detoxification
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

Covered Services, Additional Benefits and Carved-out Services

MEDICAID SERVICES	
BH, I/DD, and TBI Services Covered by BOTH Standard Plans and Tailored Plans	***BH, I/DD, and TBI Services Covered EXCLUSIVELY by Tailored Plans***
Professional treatment services in facility-based crisis program	Residential Treatment facility services
Outpatient opioid treatment	Child and adolescent day treatment services
Ambulatory detoxification	Intensive in-home services
Research-based BH treatment for Autism Spectrum Disorder (ASD)	Multi-systemic therapy services
Diagnostic Assessment	Psychiatric residential treatment facilities (PRTF)
Non-hospital medical detoxification	Assertive community treatment (ACT)
Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization	Community support team (CST)
Early and periodic screening, diagnostic, and treatment (EPSDT) services	Psychosocial rehabilitation
Inpatient BH services	Substance abuse non-medical community residential treatment
Outpatient BH services provided by direct-enrolled providers	Substance abuse medically monitored residential treatment
Psychological services in health departments and school-based health centers sponsored by health departments	Substance abuse intensive outpatient program (SAIOP)
Peer supports	Substance abuse comprehensive outpatient treatment program (SACOT)
Partial hospitalization	Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
Mobile crisis management	Waiver services
Facility-based crisis services for children and adolescents	Innovations Waiver services
	TBI Waiver services

Basic benefit services include outpatient treatment:	
Mobile Crisis Management	Medication Management
Individual, family and group therapy	Behavioral health counseling
Assessment and psychological testing	

I/DD Services Array Includes	
Respite Services	Community Navigator
Developmental Day	Supported Employment
Community Living and Support	Day Supports
Alternative Family Living (AFL)	Supported Living
Residential Supports/Group Homes	

Per Clinical Coverage Policy 8-A, Enhanced benefit services include:	
Assertive Community Treatment Team (ACT)	Day Treatment
Diagnostic Assessment	Intensive Alternative Family Treatment (IAFT)
Intensive In-Home Services (IIH)	Multi-Systemic Therapy (MST)
Community Support Team (CST)	Partial Hospitalization
Psychosocial Rehabilitation (PSR)	Outpatient Opioid Treatment
Facility Based Crisis (FBC)	Substance Abuse Comprehensive Outpatient Program (SACOT)
Substance Abuse Intensive Outpatient Program (SAIOP)	SA Medically Monitored Community Residential Treatment

Examples of Value-Added Services Tailored Plan Only	
Asthma Relief	Allergen Reduction Kit provided including furnace air filter, hypo-allergenic mattress cover, disinfecting wipes, allergen vacuum with HEPA filter sealed system, and dehumidifier. One time a year.
Child Education Support	$75 per year, per child for school supplies or online tutoring, K-12
GED Voucher	Up to $120 assistance towards GED testing cost, one time only.
Gym Memberships	Up to $250/year for specified gyms, martial arts, YMCAs, rec centers, etc.
Healthy Food Voucher	$50 food vouchers up to 4xyr for taking healthy eating/ lifestyle classes
HOMES Funds	Assistance with rent, utilities, move-in costs.
Neighborhood Connections	Neighborhood Connections team is dedicated team of specialists who assist individuals and families with housing, food access, employment, and transportation needs. Program restrictions vary.
Post Discharge Reward	$25 gift card up to 4x/yr. if follow-up visit w/ provider within 5 days of inpatient behavioral health or facility-based crisis admission.
Prenatal Wellness	Up to $100 voucher for baby supplies if prenatal, perinatal and postnatal/well child appt's are completed.
Recovery Support	Free and assisted access to already existing website/mobile app for 24/7 recovery support.
Stay Connected	One time for one year only, over age 18, free phone, minutes and data.
Tobacco Cessation	Members who engage in Tobacco Cessation Programs will be eligible to receive up to $90 in gift card rewards if specified goals are met.
Transportation Grant	Two $30 vouchers per quarter, per household, for transportation.
Wellness Rewards	$50 for completing Care Management Comprehensive Assessment, up to $120 more for (3) $40 online health coach goals completed.
Youth Support	Up to $75 per year for child after school activities/sports or youth club memberships such as Boys & Girls Club. Ages 6-18.

Value-Added Benefits

Medicaid, Trillium, and other public programs provide many additional benefits that are not considered services.

D. ELIGIBILITY FOR STATE-FUNDED SERVICES, INCLUDING FEDERAL FUNDING RESTRICTIONS AND REQUIREMENTS

Individuals who do not have Medicaid may be eligible for State-funded services based on their income and level of need. No one that meets eligibility requirements can be denied services based on inability to pay. The provider's sliding fee schedule is designed to assess a person's ability to pay.

State-Funded Eligibility Criteria For Behavioral Health (BH) Services:

- Recipient's Income is less than or equal to 300% of the federal poverty level.
- Recipient is uninsured or underinsured (has third-party insurance including Medicaid) that:
  a. Does not cover the State-funded service and there is no alternative clinically appropriate service available under the third-party or Medicaid coverage; or
  b. Covers the State-funded substance use disorder (SUD) service, but associated cost-sharing is unaffordable.
- Recipients utilizing State funds will be encouraged to apply for North Carolina Medicaid coverage.

For I/DD and TBI Services:

- No specified income limitation.
- Recipient is uninsured or underinsured (has third-party insurance including Medicaid) that does not cover the State-funded service and there is no alternative clinically appropriate service available under the third-party or Medicaid coverage.
- Recipient has applied for North Carolina Medicaid coverage.

Eligibility criteria is not applicable to behavioral health crisis services and detoxification as reflected in Department of Health and Human Services (DHHS) guidelines.

Providers requesting State Funds must ensure that the recipient(s) also meet the appropriate State Benefit Plan criteria outlined by DHHS located under the appropriate link for State Fiscal Year documents.

State-Funded Services are not an entitlement. Trillium and other Tailored Plans are not required to fund services beyond the resources that are available to them.

There are also some services, including most residential services for adults, which are not reimbursed by Medicaid. Therefore, members who receive Medicaid may also receive state-funded services based on their individual needs and availability of funding.

ELIGIBILITY FOR REIMBURSEMENT BY TRILLIUM

Individuals who have their services paid for in whole or in part by Trillium must be enrolled in the Trillium system. If you have any questions about a member's eligibility, please contact Trillium.

Those who are at 100% ability to pay according to the provider agency's sliding fee schedule, or who have insurance coverage that pays 100% of their services, must not be enrolled into the Trillium system. However, the person may still receive and pay for services from a provider independent of Trillium involvement.

Members eligible for Medicaid from counties in the Trillium catchment area are fully enrolled in the Trillium system and are eligible to receive Basic Benefit Services or Enhanced Services which have been authorized by Trillium.

E. CARE MANAGEMENT DELIVERED THROUGH THE BH I/DD TAILORED PLANS/PIHP

Tailored Care Management is a critical component of the Trillium Behavorial Health I/DD Tailored Plan/PIHP. Tailored Care Management (TCM) incorporates whole-person care that is executed with the support of an integrated care team using person-centered practices to achieve better health outcomes for our members. Whole person care incorporates all aspects of a member's needs including behavioral health, physical health, pharmacy, and unmet health related resource needs.

All Trillium Medicaid members are eligible for and automatically enrolled in Tailored Care Management with the following exceptions:

- Members obtaining Assertive Community Treatment (ACT);
- Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
- Members participating in Care Management for At-Risk Children; and
- Members participating in the High-Fidelity Wraparound program.

Trillium members are able to opt out of Tailored Care Management at any time. Those members who opt out of Tailored Care Management will be supported as need be through care coordination and care transitions.

TAILORED CARE MANAGEMENT ENTITIES

Tailored Care Management (TCM) for Medicaid can be provided through three approaches: Care Management Agencies (CMAs), AMH+ (Advanced Medical Home Plus) practices, and the BH/ IDD Tailored Plan/PIHP itself. CMAs are provider organizations with experience providing behavioral health, I/DD, and/or TBI (Traumatic Brain Injury) services to Trillium's behavioral health and I/DD population. AMH+ practices are primary care practices whose providers have experience providing primary care services to Trillium's behavioral health and I/DD population. As a Behavioral Health I/DD Tailored Plan/PIHP Trillium can also provide Tailored Care Management to its members.

All of the different approaches for TCM will be required to perform the same roles and responsibilities for Trillium's members. All entities have undergone an evaluation of their ability and been certified to execute Tailored Care Management by demonstrating their ability to support Trillium's members and meet associated requirements.

CMAs, AMH+ practices, and the Behavioral Health I/DD Tailored Plan/PIHP are monitored in the provision of TCM to ensure that all required functions of Tailored Care Management are completed within the requirements set forth by the Department of Health and Human Services (DHHS) and that the support a member receives is effective and efficient in meeting their needs.

Upon enrollment to Tailored Care Management, members receive a choice in the care management approach that they would like to receive and can select a provider of that specific TCM approach. Many factors including a member's existing provider relationships, specific behavioral health, I/DD, and/or TBI needs, complexity of medical needs, geographic location, etc. are taken into consideration when options of Tailored Care Management approach and provider are presented to the member.

ELEMENTS OF TAILORED CARE MANAGEMENT

Some of the core functions of Tailored Care Management (TCM) include but are not limited to outreach and engagement, comprehensive assessment, care planning, multi-disciplinary care team involvement, ongoing support and follow-up, support during transitions, diversion, etc. These functions are consistent for all members receiving TCM.

Although a member may be automatically enrolled in Tailored Care Management, there still needs to be outreach conducted by the provider assigned to provide TCM to ensure that the member is meaningfully engaged. This contact and engagement occurs after a member's enrollment with Trillium's BH-I/DD Tailored Plan/

PIHP. This is critical to ensuring that a member's needs can be assessed through the completion of a care management comprehensive assessment and addressed as appropriate.

The care management comprehensive assessment takes into consideration all of a member's health needs. Assessment of a member's needs includes immediate care needs, current services and providers across all health needs, functional needs, physical health conditions, current and past mental health, substance status/disorders, medication information, future planning (e.g. advanced directives, power of attorney, legal guardianship, etc.), social supports, unmet health-related resource needs, cultural considerations, employment/ community involvement, education, justice system involvement, caregiver strengths and needs, life transitions, self-management and planning skills, and entitlement benefits. The completion of the assessment is the first step in the development of the Care Plan for members with

Behavioral health needs and an Individual Support Plan (ISP) for members with I/DD and/or TBI needs. The results of the assessment are used to develop the Care Plan or ISP. The Care Plan or ISP is developed using a process that is individualized and puts the member at the center of the planning and their care and outlines a plan of action to best support the member.

The completion of the assessment and Care Plan or ISP is only possible through the support of a multidisciplinary care team. The care team is centered on the member, their needs and the supports involved in their life. Starting with the member, the care team can also include the member's caregiver/ legal guardian, doctors (e.g. primary care physician, obstetrician/gynecologist, and other specialists), behavioral health providers, I/DD and/or TBI providers, nutritionists, pharmacists, peer supports/ family navigators, and other supports as identified by the member and care manager.

ONGOING CARE MANAGEMENT

The information obtained during the assessment and Care Plan sets the stages for the actions that should be taken to support a member as part of ongoing Care Management. The responsibility of Care Management moving forward is to coordinate, refer, and provide assistance in obtaining and maintaining Medicaid, Medicare, and/or State-funded services as appropriate, services to address unmet-health related needs, and other care management supports. Care managers also work to conduct medication management and support the member's adherence to medication and other prescribed treatment regimes.

Ongoing communication with the member, legally responsible person, and other members of the Care Team is imperative and occurs regularly. Regular communication based upon the member's needs allows the care manager and other Care Team members to communicate regarding the progress towards goals in the Care Plan. Assessment and care planning become iterative processes in which the Care Team identifies member needs and coordinate to address those needs through the execution of the Care Plan or ISP. Assessment and care planning are conducted annually, when a member's needs change, at the request of the member, and at other triggering events as defined through regulatory requirements.

i. In-reach

For those members already residing in institutional settings or other higher levels of care that include as Adult Care Homes (ACH), State psychiatric hospitals, State developmental centers, Psychiatric Residential Treatment Facilities (PRTF), and Residential Treatment Levels II/ Program Type III, Care Management will conduct in-reach activities to identify those members who may be able to have their needs safely met in a community setting. AMH+ practices and CMAs are able to provide in-reach and transition services to children and youth admitted to a state psychiatric hospital, PRTF, or Residential Treatment Levels II/ Program Type, III, and IV. For adults, AMH+ practices and CMAs can provide in-reach and transition services to those admitted to a state psychiatric hospital or an Adult Care Home (ACH) who are eligible for Tailored Care Management and who are not transitioning to supportive housing. For those members that are identified as being able to be supported in the community, in-reach services will provide education on peer support/family navigator services and other services/supports available to help support the member in the community, facilitate visits to Community-based services, and identify and address barriers to and concerns with moving to a community-based setting.

If a member decides to transition to a community-based setting, Care managers will work to initiate transition planning with the member's identified Care Team. Transition planning will work to detect a member's needs and link members with supports/ services (i.e. primary care physician, behavioral health providers, I/DD or TBI providers, medical specialists, etc.) among other activities to ensure a safe transition into the community for the member.

ii. Transition Management

Members will move between different clinical settings and services as their needs change and evolve. Care Management will assist members in making these transitions to prevent any adverse consequences such as admissions or readmissions to the hospital, visits to the emergency department, etc. Care managers work closely with the member and the Care Team to proactively plan for these transitions, to support them during the transition, and follow-up afterwards for continuity of care.

iii. Diversion

Care Management works to support the values of community-based services/supports ensuring that members are able to reside in the community and setting of their choosing. To help members accomplish and maintain these values, care managers perform diversion activities as need be for those members who meet certain requirement such as seeking entry to or recently admitted to an institutional setting or ACH or meeting other pre-established criteria for members with I/DD or TBI. Care managers support members by educating them on their eligibility for community-based services, referring and linking the member with those services, assisting with housing as needed, and developing and implementing a Community Integration Plan.

CHILDREN AND YOUTH SERVICES

Children and Youth Services is responsible for enhancing relationships with Department of Juvenile Justice (DJJ), Department of Social Services (DSS), local health departments and other community stakeholders. Children and Youth services addresses youth with integrated care needs ranging from ages 0-18 and up to 21 for youth remaining in the 18-21 DSS Foster Care Programs. This unit is a support mechanism to external stakeholders in navigating Trillium systems and service array in order to promote integrated care for children and youth. Another key focus is to work with internal departments and external entities to build a healthy network of providers, ensuring gaps in services are identified through eliciting stakeholders' feedback while seeking resources to fill these gaps. Children and Youth Services is also instrumental in working with stakeholders to ensure appropriate linkage to assessments and evaluations in order to facilitate access to care.

PRIMARY CARE PROVIDER RESPONSIBILITIES

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

CLINICAL SUPPORT

The primary purpose of the Clinical Support Unit is to triage Care Management/Care Coordination matters and send to the appropriate Care Management/Care Coordination team or appropriate business unit for processing. Items which fall under the purview of the Clinical Support Unit range from processing requests for Care Management and Care Coordination, Care Management related SNOW tickets, TCM Provider requests for assistance, to processing Primary Care Physician requests for Care Management assistance.

HOUSING

The Housing Department works to ensure members/recipients have options for safe, decent and affordable housing. Housing staff members serve on, facilitate and support community groups, boards, councils and organizations that share the Trillium goal of welcoming people with disabilities into the community.

Housing staff procure grants to expand community capacity for stable housing options that provide the opportunity for growth, skill building, and increased independent living.

They maintain an inventory of housing resources and information on the unmet housing needs of members/recipients and families served.

Providers may seek assistance from Housing staff for members who are seeking safe and affordable housing. Staff can also provide or arrange for education to providers on a variety of housing topics such as North Carolina Fair Housing Law and How to Be a Good Landlord/Tenant.

NEIGHBORHOOD CONNECTIONS

The Neighborhood Connections Department works to enhance and increase the accessibility and availability of resources that influence a person's overall health and wellness. The department includes teams that coordinate: the Registry of Unmet Needs; specialty care needs such as assistive technologies, home and vehicle modifications, and community networking classes; residential searches; and assisting members with non-medical drivers of health such as food access, transportation, housing, education/ employment, inclusion and interpersonal safety. Neighborhood Connections specialists offer wellness education in partnership with providers and community based organizations

TRILLIUM ADVANTAGE

Trillium Advantage covers services and settings not currently available to members in North Carolina Medicaid. These options are better suited to meet the individual needs of our members that may not be covered by typical behavioral health or I/DD services. We will offer value-added services to help address unmet health-related resource needs.

F. PROVIDER RESPONSIBILITIES

Your responsibility as a Trillium Contracted Provider related to Members' Rights is to:

- Respect members' rights at all times.
- Provide continual education to members regarding their rights, as well as support them in exercising their rights to the fullest extent.
- Be knowledgeable of, and develop operational procedures to ensure compliance with, all outlined statutes and regulations regarding member rights and the use of restrictive interventions and protective devices.
- Maintain an ongoing knowledge of changes to the statutes and regulations and immediately alter operations to meet changes.
- Maintain a Client Rights Committee consistent with regulations outlined in North Carolina General Statute and Administrative Code.
- Advocate for medical care or treatment options.
- Provide information the member needs in order to decide among all relevant treatment options.
- Provide information to the member about the risks, benefits, and consequences of treatment or non-treatment options.
- Provide information to the member about his/her right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.
- Be aware that requesting a second opinion is a right of all Medicaid members and refer the member to contact the toll-free Trillium's Member and Recipient Services at 1-877-685-2415 if a second opinion is requested.
- Discuss with members any specific requests they may have regarding their care.
- Respect the wishes expressed in an Advance Instruction for Mental Health Treatment, or other legal advance directive and make it part of the person's medical record.
- Maintain the confidentiality of all members and other information received in the course of providing services.
- Avoid discussing, transmitting, or narrating any member information in any form—personal, medical or otherwise—unless authorized in writing by the member or his legally responsible person, or as otherwise permitted by federal and state confidentiality laws and regulations.
- Comply with Title VI of the Civil Rights Act of 1964 by making services linguistically accessible by providing free language assistance through translated materials, interpreters or bilingual staff.

Your responsibility as a Trillium Contracted Provider related to Contracts is to:

- Review your contract for accuracy and fully execute the contract and return to Trillium within ten business days of receipt to assure continued payment for services.
- Sign and have a fully executed Trillium Contract Amendment for any material change to the original contract.
- Have a current disaster plan, including evacuation and fire plan, if providing services in a facility provide services only at qualified service sites as are approved in Provider Direct.
- Adhere to all performance guidelines in your contract and work to deliver best practices.
- Comply with the policies and procedures outlined in this manual, any applicable supplements, your provider contract, the general conditions of the procurement contract, and applicable State and federal laws and regulations.
- Understand the obligations and comply with all terms of the contract.
- Notify Trillium of any prospective changes in site(s) and assure all Trillium qualification requirements are met and any contract amendments are in place prior to delivery of contracted services.
- Periodically review your contracted site information in Provider Direct and make sure that all NPI numbers, address information and taxonomies are current and have correct linkage at NCTracks.
- Monitor your health plan enrollment in NCTracks to ensure it remains active.

Your responsibility as a Trillium Contracted Provider related to Training is to:

- Participate in ongoing training opportunities as applicable.
- Review the Trillium website for updates on a regular basis.
- Review the State websites for most up-to-date information on a regular basis (see Resources & Web Links section of this manual).
- Offer provider training on empowering people served to be prepared for disaster and crisis.

Your responsibility as a Trillium Contracted Provider related to Information Technology is to:

- Have and maintain high speed Internet connectivity.
- Provide complete and accurate data in all submissions to Trillium.
- Comply with HIPAA Security Regulations.
- Subscribe yourself and as many staff from across your company as needed for effective communication (subscribe to Constant Contact).
- Avoid blocking Trillium domain emails.
- Manage your email inbox to avoid "bounce back" or undeliverable messages.
- Must complete the Provider Direct System Administrator training on Provider.MyLearningCampus.org before receiving access to Provider Direct.

Your responsibility as a Trillium Contracted Provider related to Network is to:

- Work in collaboration with other providers, members and families.
- Work on a solution-focused and collaborative basis within the network.
- Demonstrate member-friendly services and attitude to ensure good communication with member/recipient and families.
- Have a clinical backup system in place to respond to emergencies on weekends and evenings for people you serve, or serve as a first responder as outlined in the service definition and your contract.
- Provide services only at qualified service sites as outlined in your contract.
- Strive to achieve best practice in every area of service.
- Adhere to all performance guidelines in your contract and work to deliver best practices.
- Actively participate in member/recipient satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements.
- Conduct self-monitoring activities for compliance and develop and implement plans of correction for any non-compliance identified.
- Maintain services at an optimal level to meet member/recipient needs by providing services in accordance with Trillium Clinical Practice Guidelines.
- Attempt to first resolve any disputes with other network providers or Trillium through direct contact or mediation.
- Keep apprised of current information through the communication offered and provide services per the most recent State standards or waiver service definitions.
- Comply with the policies and procedures outlined in this manual, any applicable supplements, your provider contract, the general conditions of the procurement contract, and applicable Sate and federal laws and Regulations.
- Understand the obligations and comply with all terms of the contract and all requirements in the Trillium Provider Manual
- Use best efforts to report to the county DSS any known change in the household composition affecting the member's eligibility for Medicaid (including changes to family size, marital status or residence) within five (5) (business days of such information being reasonably and reliably known to the provider.
- Notify Trillium of any prospective changes in site(s) and assure all Trillium qualification requirements are met and any contract amendments are in place prior to delivery of contracted services.
- Notify Trillium in advance of any mergers or change in ownership because it may have implications for your contract status with Trillium.
- Maintain all licenses, certifications, accreditations, credentialing and registrations required for your facilities and staff providing services to Trillium members and recipients.

- Notify Trillium in writing within five (5) business days of personnel changes or information updates which may include, but is not limited to changes in capacity including inability to accept new referrals, addition of capacity or specialty services, address changes as well as changes in other enrollment information.
- Notify Trillium in writing if you wish to take a leave of absence. Notification must occur no later than 60 days prior to the desired effective date.
- Do not request more than six (6) months in an initial leave of absence, with the option for an extension, unless the leave is a result of disabling illness.
- Comply with Clinical Coverage Policy 8-P North Carolina Innovations related to residential services. Private home respite services serving individuals outside their private homes are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month. An Alternative Family Living (AFL) site shall be licensed if serving either (1) one or more minor clients or (2) two or more adults clients. Minor and adult clients shall not reside in the same location. Unlicensed supervised living homes (AFLs) may only serve one adult as criteria not being met for 10A NCAC 27 G.5601 (b) (1) or (2).
- Submit request for an extension no later than 60 days prior to the expiration of the original leave of absence. Extension to the original leave may not exceed an additional six (6) months.
- Adhere to the regulations set forth for record retention as addressed in the following: DHHS Records Retention and Disposition Schedule for Grants; the Records Retention and Disposition Schedule for State; APSM 10-3 Records Retention and Disposition Schedule; and APSM 10-5, Records Retention and Disposition Schedule.
- Transfer all member and recipient records to Trillium upon termination of the Trillium provider contract.
- Maintain the required insurance stated in your Contract.

Your responsibility as a Trillium Contracted Provider related to Credentialing is to:

- Provide services for which you are qualified and credentialed by NCDHHS.
- Enroll and maintain active status in NCTracks with an active Medicaid Health Plan.
- Satisfy all application requirements and have a fully executed contract prior to delivery of services to any Trillium member.
- Complete the re-credentialing process as directed by NCDHHS, with all required documentation in a timely manner to avoid expiration.

Your responsibility as a Trillium Contracted Provider related to Crisis Care & Service Enrollment is to:

- Publish and make available the toll-free Trillium Member and Recipient Services line for members, recipients and family members, along with the telephone number for Disability Rights of North Carolina.
- Cooperate fully with all investigative requests. Refusal to comply with any grievance follow-up or investigation is a breach of contract.
- Provide and comply with face-to-face emergency care within two (2) hours (Emergent Request) after a request for care is received by provider staff initiated by member. The provider must provide face-to-face emergency care immediately for life threatening emergencies.
- Provide and comply with initial face-to-face assessments and/or treatment within 48 hours (Urgent Request) after the day and time a request for care is received by provider.
- Provide and comply with initial face-to-face assessments and/or treatment within 10 calendar days (Routine Request) of the date a request for care is received by provider.
- Provide return telephone calls within one hour, 24 hours a day, 7 days a week.
- Be responsive and comply with emergency referrals within one hour, 24-hours a day, 7 days a week.
- Maintain systems and procedures to ensure members with scheduled appointments are being seen within the required wait time of 60 minutes after the appointed meeting time.

- Maintain systems and procedures to ensure members who walk in are being seen within the required wait time of two (2) hours after the arrival.
- Develop and implement policies and procedures for receiving and handling complaints and grievances.
- Incorporate results of grievances or complaints into your internal quality assurance/quality improvement committee to assure systemic issues related to the complaint are being addressed.
- Develop and implement a process to inform members/families of your policy and procedures on complaints.
- Be responsive to complaints and cooperate fully with the Tailored Plan in investigating and resolving complaints within timeframes established by the Tailored Plan.
- Provide to Trillium, copies of supporting documentation and evidence regarding your agency's investigation (i.e., PCP's, service notes, service orders, etc.) as well as citations of statutes and rules pertinent to each allegation or complaint in order to resolve issues.
- Comply with NC law (N.C.G.S. §122C-18) regarding retaliation against a person for complaining to a member advocate.
- Ensure there are no barriers to treatment, system navigation is friendly, and the screening process is the same no matter where the member presents to be seen.
- Maintain systems and procedures to screen and triage member needs—whether by phone or walk-in—and schedule that person for an appointment within required timeline.
- Be as clear as possible in requests for information or services to enable our Call Center & Member Service Center to help you in the most efficient and effective way possible.

Your responsibility as a Trillium Contracted Provider related to Utilization Management is to:

- Obtain authorizations as required for contracted services.
- Ensure members/recipients meet medical necessity requirements for all services your agency provides
- Provide medically necessary covered services to members as per your contract and authorized by Trillium.
- Comply with Trillium authorization requirements
- Document all services provided per Medicaid requirements, NC waiver requirements and North Carolina State rules.
- Add service openings in the Registry of Unmet Needs available in Provider Direct; search for, review and place members who are appropriate for the vacancy based on the criteria entered.
- Submit Treatment Authorization Requests (TARs) with the proper clinical information at least 14 days prior to the end date of the current authorization to allow for Utilization Management activities and authorization prior to beginning services.
- Submit continuing TARs on a timely basis to allow for Utilization Management activities and authorization prior to beginning services;
- Emergency authorizations are available, but should only be used when necessary to provide for health, safety and wellbeing.
- Submit an expedited request for emergency/acute care within 48 hours of admission.
- Maintain services at an optimal level to meet member/recipient needs by providing services in accordance with Trillium's Clinical Practice Guidelines.
- Participate actively in a person-centered planning process with others serving the member to develop a comprehensive Person-Centered Plan/ISP/treatment plan development of treatment and/or habilitative programs that are in accordance with the person-centered plan/ISP/treatment plan.

Your responsibility as a Trillium Contracted Provider related to Care Management is to:

- Comply with Trillium care managers' requirements.
- Work with Trillium to ensure a smooth transfer for any members who desire to change providers, or when you need to discharge a member because you cannot meet their special needs.

- Communicate with the care coordinator about the needs of members that you support.
- Notify the care coordinator of any changes, incidents, other information of significance related to the member supported.
- Ensure that members are appropriately linked to primary health care.
- Assist with referrals to natural and community supports.
- Follow up with a phone call whenever a member who is considered high-risk misses an urgent or emergent appointment. Send a letter if unable to contact the member by phone, and document within the member's chart all attempts to reach them.
- Contact Trillium care managers whenever an individual receiving care management misses two appointments.
- Contact Trillium care managers for members on an outpatient commitment order who fail to keep any appointment.
- Educate members on Medicaid transportation.
- Provide accurate and timely responses to TARs.
- 14 calendar days for a routine request.
- 72 hours for an expedited request.
- Ensure members/recipients receive medically necessary services.
- Ensure members/recipients who need a service are listed in the system.
- Inform providers of members/recipients receiving care management.
- Complete telephonic or on-site visits to monitor the health and safety of the member/recipient receiving care management.
- Assess the satisfaction of members/recipients served.
- Monitor implementation of the Individual Support Plan (ISP) or Person-Centered Plan (PCP).
- Communicate with providers on any additional assessments needed.
- Develop and share ISPs. Communicate any recommendations for development or revisions on the PCP/ISP/treatment plan.
- Educate members/recipients receiving care management on Medicaid transportation.
- Share natural and community resources for referrals and linking.

Your responsibility as a Trillium Contracted Provider related to Billing and Claims is to:

- Verify member insurance coverage at the time of referral/admission or each appointment; and on a quarterly basis.
- Determine the member's ability to pay using your agency's sliding fee schedule for all designated non-Medicaid services based on your agency's contract requirements.
- Bill all first and third party payers prior to submitting claims to Trillium.
- Report all first party required fees and third party payments and denials on the claim.
- Submit Medicaid Funded clean claims electronically within 365 calendar days and State Funded clean claims electronically within 90 calendar days of the service date, unless otherwise stated in your contract.
- Ensure all billing submitted for payment is supported by documentation meeting all requirements for billing a service.
- Ensure all documentation regarding services provided is timely, accurate, and complete.
- Identify all billing errors to the Trillium Claims Department.
- Self-initiate paybacks for services billed in error or without supporting documentation.
- Manage your agency's Accounts Receivable.
- Submit all documentation which is required for federal, state, or grant reporting requirements. This includes, but is not limited to, required enrollment demographics that must be reported to the State by Trillium.

G. NETWORK REQUIREMENTS

i. Nondiscrimination

Trillium will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, gender identity, color, creed, religion, national origin, ancestry, sex, sexual orientation, age, veteran or marital status, or any unlawful basis not specifically mentioned herein. Additionally, Trillium will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to members to meet their needs and preferences, this information is not required in the contracting process. Decisions are based on issues of professional conduct and competence as reported and verified through the contracting process.

Trillium's procedures and processes will not discriminate against any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification with regards to participation, reimbursement or indemnification.

ii. Cultural and Linguistic Competency Expectations

Cultural Competence

- Be responsive to the cultural and linguistic needs of the members served.
- Interact effectively with members of different cultures.
- Acknowledge the importance of different cultures and languages.
- Embrace cultural strengths with people and communities and understand cultural and linguistic differences.
- Earnestly participate in initiatives to achieve cultural competence, such as trainings and other development opportunities.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner.
- Provide culturally competent services and ensure the cultural sensitivity of staff members.
- Develop a cultural competency plan and comply with cultural competency requirements.
- Ensure members understand they have access to medical interpreters, signers and TDD/TTY services without cost to them.
- Ensure care is provided with consideration of member's race/ethnicity and language.
- Make reasonable attempts to collect race and language specific information. Assist in explaining race/ethnicity categories to a member so they are able to identify with appropriate race/ethnicity.
- Office locations have posted and printed materials in English and Spanish, and other non-English languages, if requested.

Trillium's Responsibility to Providers is to:

- Provide evaluative feedback relative to proficiency in providing culturally competent services.

iii. On-call Coverage

- Providers must be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care. Refer to Locum Tenens Policy.

iv. Credentialing and Re-credentialing/Network Participation

Trillium has developed as part of its Provider Manual, written policies for the selection and retention of network providers and applies criteria consistent across all providers. This information is published on Trillium's website, including current and previous versions including effective dates.

Trillium follows the NC Department of Health and Human Services' (the Department) Uniform Credentialing and Recredentialing Policy and requires that all providers enroll, credential, and re-credential with the Department as a North Carolina Medicaid or State-funded services provider consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E to be considered for participation in Trillium's network. This applies to all provider types: individual and

organizational, including acute, primary, pharmacy, mental health, substance use disorders, intellectual and developmental disability, traumatic brain injury, and long-term services and supports providers. This includes in-state providers, border (i.e., providers who reside within 40 miles of the NC state line), and out of state network providers. Trillium adheres to the Department's requirements for the credentialing and re-credentialing of providers and will confirm a provider's active status on the Provider Enrollment File (PEF) for verification of credentialing/ re-credentialing by the Department. Trillium shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department. Trillium utilizes a standardized process for network provider selection and retention. 42 C.F.R. § 438.12(a)(2).

Trillium shall validate that providers are active utilizing the PEF to ensure providers are eligible for contracting. Trillium receives the PEF via a secure file transfer protocol (FTP) and utilizes the information received to make network contracting decisions in compliance with 42 C.F.R. § 438.206(b)(6.

Trillium shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment 42 C.F.R. § 438.214(c).

Trillium shall not discriminate against a provider for filing a grievance on behalf of and with the written consent of a member or helping a member to file a grievance or for protesting a plan decision, policy or practice the health care provider believes interferes with its ability to provide medically necessary and appropriate health care.

Trillium shall prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

Providers must complete information requested by Trillium, Carolina Complete Health, or PerformRx for network contracting decisions. For behavioral health and I/DD providers, this includes a Network Participation Application, including demographic data to validate identification on the PEF, additional Provider Directory information as required by the Department, and financial forms required for payment.

Trillium has the right to make the final determination about which providers participate within its network.

Trillium shall not use, disclose, or share provider credentialing information for any purposes other than use in Medicaid Managed Care without the express written consent of the provider and the Department.

Trillium may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, for up to one hundred twenty (120) days but must terminate a Network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected members. 42 C.F.R. § 438.602(b)(2).

Trillium shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) Calendar Days of suspension, the Department will terminate the provider from Medicaid.

Physical Health and Pharmacy

All network contracting decisions for physical health providers, Non-Emergency Medical Transportation (NEMT) providers, Long-Term Support Services providers, and their affiliated practitioners will be completed by Carolina Complete Health.

All network contracting decisions for pharmacy providers will be completed by PerformRx.

Carolina Complete Health and PerformRx will make network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the information provided by the Department on the PEF for any willing provider and acceptance of the contracting terms and rates. Neither Carolina Complete Health nor PerformRx shall contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

Behavioral Health (BH), Intellectual and Developmental Disabilities (I/DD), and Traumatic Brain Injury (TBI) services

Trillium shall make network contracting decisions for Medicaid and State Funded providers of BH, I/DD, and TBI services based upon the credentialing information provided by the Department on the PEF and information collected from the provider to make contracting decisions, including an assessment of the provider's ability to deliver care. This shall include validation of license and accreditation in compliance with relevant Clinical Coverage Policies and/or Service Definitions.

Trillium maintains a restricted/closed network for the services as set forth in Section 4. (10)(a)(1)(IV) Of Session Law 2018-48 and N.C. Gen Stat 108D 23. Trillium utilizes data related to network adequacy standards including time and distance and appointment wait times, as well as additional reports on member needs, to determine if additional network providers are needed. Trillium will review all BH, I/DD, and TBI service providers based on network adequacy and member needs.

Trillium shall obtain approval from the Department before using, disclosing, or sharing provider credentialing information for any purpose other than use in Medicaid Services.

State-Funded Providers

Each provider that is credentialed to provide only State-funded services (State-funded only provider) must enroll in Medicaid during its next recredentialing period. The period between BH I/DD Tailored Plan launch and when all State-funded only providers are credentialed with Medicaid will be considered the "State-funded Only Provider Credentialing Transition Period."

During the State-funded Only Provider Credentialing Transition Period, if a provider is not enrolled and credentialed with the Department, Trillium shall monitor and maintain credentialing records for State-funded only providers to ensure continued compliance with credentialing requirements and ensure that each State-funded only provider transitions to Medicaid enrollment during its recredentialing period. These records shall be made available to DMH/DD/SAS for inspection if requested. During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Department's Provider Enrollment Process, Trillium will evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. Trillium's process will occur no less frequently than every five (5) years consistent with the Department's policy and procedure. After the Provider Credentialing Transition Period, Trillium will evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. This process will occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.

Provider Sanction Monitoring

Trillium conducts initial and ongoing monitoring activities on all behaviorial health and I/DD network providers to ensure continued compliance with network participation standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. Trillium shall not contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

Re-Credentialing

During the Provider Credentialing Transition Period the Department will re-credential providers every five (5) years. After the Provider Credentialing Transition period, the Department will re-credential providers every 3 years (36 months). Trillium suspends claims payment to any provider for dates of services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. Trillium reinstates payment to the provider upon notice that the Department has received the requested information from the provider.

Trillium is not liable for interests, liquidated damages, or penalties for payment suspension at re-credentialing, when directed by the Department.

If a provider fails to re-enroll or re-credential with the Department or designated vendor, the provider will be unable to be paid for services rendered until an updated credentialing file is received from the Department. Providers cannot be reimbursed for services if credentialing has expired.

In addition to the Department's re-credentialing process, Trillium also evaluates provider's continued eligibility based on the above timelines as well as on a daily basis utilizing information on the Provider Enrollment File. This process is consistent with the Department's Uniform Credentialing and Re-credentialing Policy.

Provider Notification

Trillium provides written notice of network contracting decisions to providers within five (5) business days of determination of the provider's status as an active Medicaid or State-funded services enrolled providers.

Provider Disenrollment and Termination

Trillium will suspend claims payment to any provider for dates of services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise failing to meet Department requirements.

Trillium will reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) calendar days of suspension the Department will terminate the provider from Medicaid. Trillium is not liable for interest or penalties for late claim payment related to payment suspension.

Trillium may terminate a provider from its Network with or without cause. Any decision to terminate must comply with the requirements of the Contract.

Termination by the Department

Trillium will remove any provider from the claims payment system, and terminate its contract within one (1) business day of receipt of a notice from the Department that the provider is terminated. This applies to all providers, regardless of the provider's network status. If Trillium suspended the provider payment, then upon notice by the Department that the provider is terminated, Trillium will release applicable claims and deny payment for dates of service after the date of termination. There are no appeal rights against Trillium for a provider terminated or sanctioned, including suspension of provider payment, by the Department.

Trillium will provide written notice to the provider of Trillium's action to terminate the contract. The termination notice will provide the reason for Trillium's decision, the effective date of the termination, the provider's right to appeal, and how to request an appeal, if applicable.

Contracting Information Required

The information, below, is collected from the provider for contracting purposes to support claim payment, directories and data management.

Providers shall submit the following information on the corresponding submission form:

Office Site

- Provider's office handicap accessibility status
- Provider's office hours
- Provider's website
- Fax number of service address
- Provider 24-hours status
- After-hours telephone number

Financial

- Tax (W9) Request for Taxpayer Identification Number and Certification
- Electronic Funds Transfer Documents
- Deficit Reduction Act Attestation

Data Exchange

- Trading Partner Agreement
- Provider Direct System Administrator Designee Request Form

Practitioner Information

- PCP or Specialist Status
- New Member Acceptance Status
- Identification of member age restrictions
- Practitioner's hospital affiliations and/or admitting privileges
- Languages spoken by the provider and office staff other than English
- Completion status of cultural competency training.

PROVIDER VIOLATIONS AND SANCTIONS

Violations

Violations are categorized broadly as those pertaining to issues of professional competence or conduct and those pertaining to administrative matters.

Violations include, but are not limited to:

- Poor quality of care.
- Inappropriate use of clinical interventions.
- Inappropriate or incomplete adherence to a service definition or best practice.
- Inappropriate relationships/professional boundaries.
- Failure to comply with standards of practice.
- Actions jeopardizing professional ethics.
- Lack of verification of experience as required.
- Failure to deliver/document the service as required by the service definition.
- Failure to submit, revise, or implement a plan of correction within the specified timeframes.
- Failure to comply with the explicit requirements of the contract and the controlling authority identified in the contract.
- Failure to maintain required license(s), accreditation or credentialing with the Department.
- Failure to maintain, make available or securely retain service records in accordance with federal or state law and NC DHHS policy.
- Suspension by any applicable government authority.
- Failure to maintain the required minimum liability insurance coverage.
- Failure to comply with the Health Insurance Portability and Accountability Act (HIPAA).
- Any instance of fraud, waste or abuse, including altering documents, falsifying records, submitting false claims.
- Evidence of substantial failure to comply with regulatory standards as defined by North Carolina Statutes and Rules for Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/IDD/SAS).

Trillium may impose sanctions on a network provider for a variety of reasons, including but not limited to violations related to contractual obligations, state and federal laws, rules, regulations and policies set to protect the health and safety of members/recipients. Sanctions imposed by Trillium may be progressive or cumulative in order to address the specific area(s) of violation and/or Contract that are not being fulfilled by the network provider.

Trillium makes every effort to expedite the investigation of these cases, especially if the provider has been suspended. However, Trillium does not compromise the outcomes to complete the case quickly; therefore, Trillium follows the same deadlines in all cases. A suspended network provider may not receive authorizations or receive new referrals from Trillium pending review and/or investigation.

In addition, Trillium may provide written notification, as appropriate, to the following external authorities:

- Division of Health Service Regulation (DHSR)
- Department of Social Services (DSS)
- Division of Mental Health, Developmental Disabilities, Substance Abuse Services (DMH/DD/SAS)—Program Accountability Unit
- Division of Health Benefits (DHB)—Office of Compliance and Program Integrity Unit

Technical Guidance, Disciplinary Actions and Sanctions

Technical Guidance, disciplinary actions or sanctions that can be taken against a network provider include, but are not limited to, any one or a combination of the following:

- Education and/or technical assistance given to the provider
- Referral Freeze
- Recoupment
- Plan of Correction (POC)
- Additional monitoring
- Self-audit review of documentation and/or paid claims
- Monetary Penalty or Liquidated Damages
- Transfer—Offer provider choice and transition of Tailored Plan funded members to another provider
- Additional audits, including prepayment claims review
- Denial of network participation of individual practitioners within the agency/provider
- Suspension of referrals
- Termination of contract(s)
- Referral to another regulatory body

If the chief medical officer or clinical director is of the opinion that the provider in question poses a significant risk to the health, welfare, or safety of members, the provider may be immediately suspended pending the results of the investigation.

Sanctions imposed by Trillium may be progressive or cumulative in order to address the specific area(s) of the contract that are not being fulfilled by the network provider.

v. Access Requirements

Trillium network providers are held to Appointment Wait Times for Medicaid, Medicaid Direct, and State-funded, see section I Network Adequacy and Access Standards. Trillium will monitor Network providers regularly to determine compliance with the timely access requirements and take corrective action if it, or its network providers, fail to comply with the timely access requirements.

vii. Notification of Changes in Address

Trillium network providers are required to update their address and make other changes by using the Manage Change Request form in NCTracks. This may include, but is not limited to changes in capacity including inability to accept new patients , addition of capacity or specialty services, address changes as well as changes in other provider information.

viii. No-reject Requirements

Trillium's contract with network providers addresses how the providers will have a "no reject" policy for members/recipients who have been determined to meet medical necessity for the covered services provided by a provider or as a licensed practitioner (LP). Providers agree to accept all referrals meeting criteria for services they provide when there is available capacity.

ix. Licensure Requirements

- Maintain all licenses, certifications, accreditations, credentialing with the Department and registrations required for your facilities and staff providing services to Trillium members and recipients.
- Notify Trillium within ten (10) business days of any change in the status of licenses, accreditations, certifications and the status of such in accordance with applicable licensing boards, administrative code, and clinical coverage policy.

x. Insurance Requirements

Maintain the required insurance stated in your contract.

xi. Required Availability

Accessing Emergent Services

The access standard for Emergency Services is two (2) hours or immediately, for life-threatening emergencies.

If member/recipient requires urgent care, they are referred to a provider regardless of funding status (Medicaid, Medicare, Insurance, etc.).

For detailed information regarding required availability refer to Section I. Network Adequacy and Access Standards.

H. TELEHEALTH

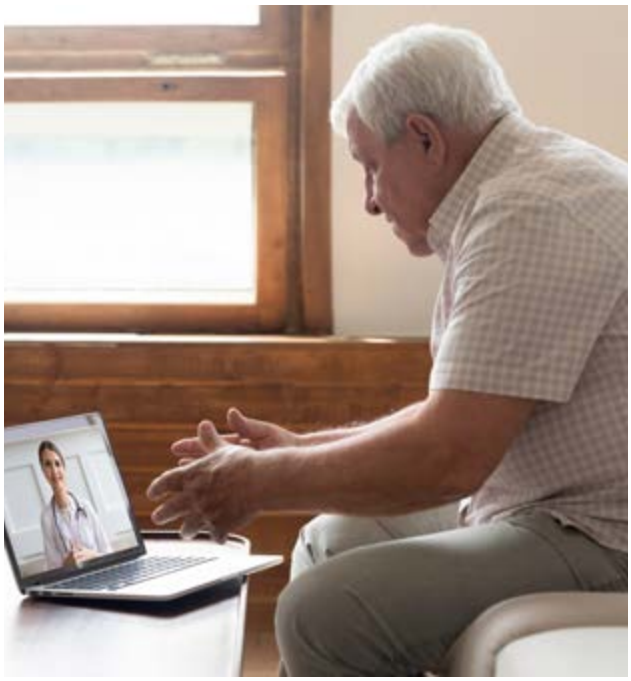
Trillium is dedicated to transforming virtual member and provider communications to increase access to services and care through telehealth, telemedicine, and remote patient monitoring to ensure the health and safety as well as the continuity of care for all of our beneficiaries. Trillium's approach for the use of these services is aligned with the North Carolina Department of Health and Human Services (NCDHHS) goals and contractual requirements.

Telehealth is a covered plan benefit by Trillium that is subject to limitations, guidelines, and contractual policies/ requirements as set forth by NCDHHS. Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

Virtual Patient Communications

Virtual Patient Communications is a covered plan benefit by Trillium that is subject to limitations, guidelines, and contractual policies/requirements as set forth by NCDHHS.

Virtual communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a beneficiary or a provider and another provider.



Covered virtual communication services include telephone conversations (audio only), virtual portal communications (secure messaging), and store and forward (transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

Remote Patient Monitoring

Remote patient monitoring is a covered plan benefit by Trillium that is subject to limitations, guidelines, and contractual policies/requirements as set forth by the NCDHHS. Remote patient monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (blood pressure, heart rate, weight, and blood oxygen levels) in order to make treatment recommendations.

There are two types of remote patient monitoring:

1. **Self-Measured and Reported Monitoring**: When a beneficiary uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
2. **Remote Physiologic Monitoring**: When a beneficiary's physiologic data is wirelessly synced from a beneficiary's digital device where it can be evaluated immediately or at a later time by a provider.

I. NETWORK ADEQUACY AND ACCESS STANDARDS

Trillium will contract a network that complies with NCDHHS Network Adequacy standards and will reassess the adequacy of the network to ensure on an ongoing basis that Medicaid Members, Medicaid Direct members, and State-funded recipients (Members) have appropriate access to care. For State-funded services, Trillium assesses availability of funds for all services managed in the State-funded benefit plan.

Trillium completes an annual Network Analysis to evaluate the capacity of the contracted provider network to meet the needs of the people served, and to measure geographic access to provider locations.

Trillium's primary goal is to ensure choice and to develop provider expertise in evidence-based practices of care so the system can be shaped to better meet the needs of individuals we serve.

Network Gaps

Request for Proposal (RFP), Request for Application (RFA) and Request for Information (RFI) process is to solicit proposals, applications or information for the development, improvement, support of and/or delivery of services.

This is a competitive, open and non-discriminatory process. Solicitations are based on priorities outlined in the Network Access Plan, North Carolina Service Definitions, and/or identified in the Annual Network Analysis. The process of developing any RFA/RFP/RFI may include some or all of the following: a determination and prioritization of need, funding sources, and cost/benefit analysis. A transparent and equitable scoring process will be utilized to assess competencies specific to the requirements of the solicitation.

Please see RFPs/RFAs posted on our website for needs/gaps in our network. To make contract requests outside of the RFPs/RFAs, please email NetworkServicesSupport@TrilliumNC.org for further consideration.

PROVIDER LOCATIONS AND AVAILABILITY

In order to ensure that all Medicaid members, Medicaid Direct members, and State-funded recipients have timely access to all covered health care services in each benefit plan, Trillium ensures its network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers for Medicaid, Medicaid Direct, and for State-funded services. Certain service types apply to both adult and pediatric provider standards. These service types are marked with a (*) and include hospitals, pharmacies, occupational, physical, or speech therapists, pulmonology specialty, LTSS, and nursing facilities.

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

For purposes of network adequacy standards for substance use disorder and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is age 18 or older, and pediatric/adolescent (child/children) services are those provided to a member who is younger than age 18. Trillium is required to use the definitions of service categories for behavioral health time/distance standards in the following tables.

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID

Service Type	Urban Standard	Rural Standard
Primary Care[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
Obstetrics[2]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members Research-based BH treatment for autism spectrum disorder (ASD): Not subject to standard	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members Research-based BH treatment for autism spectrum disorder (ASD): Not subject to standard
Location-Based Services	• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard	• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID

Service Type	Urban Standard	Rural Standard
Crisis Services	• Professional treatment services in facility-based crisis program: The greater of: ° 2+ facilities within each BH I/DD Tailored Plan Region, OR ° 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • Facility-based crisis services for children and adolescents: ≥ 1 provider within each BH I/DD Tailored Plan Region • Medically monitored inpatient withdrawal services:(non-hospital medical detoxification) ≥ 2 provider within each BH I/DD Tailored Plan Region • Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification), Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal (social setting detoxification): ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard	
Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
All State Plan LTSS (except nursing facilities)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID

Service Type	Urban Standard	Rural Standard
Residential Treatment Services	• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region • Medically Monitored Intensive Inpatient Services (substance abuse medically monitored community residential treatment): Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to 10A NCAC 27G.3400) • Clinically managed residential services (substance abuse non-medical community residential treatment): ° Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by NCDHHS) ° Adolescent: Contract with all designated CASPs statewide ° Women & Children: Contract with all designated CASPs statewide • Clinically managed population-specific high-intensity residential program: contract with all designated CASPs • Clinically managed low-intensity residential treatment services (substance abuse halfway house) ° Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)2 ° Adolescent: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E) (3) • Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard	
1915(c) HCBS Waiver Services: NC Innovations	• Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. • Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard	
1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment: ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan region. • Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports: ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan region. • Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification: N/A	

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID		
Service Type	***Urban Standard***	***Rural Standard***
Employment and Housing Services	• Individual Placement and Supports (IPS) – Supported Employment (Adult MH): Eligible individuals shall have the choice of at least 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients.	
1915(i) Services	• Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) service within each BH I/DD Tailored Plan Region. • In-Home Respite: ≥ 2 providers within 45 minutes of the member's residence. Community Transition: Not subject to standard	

[1] Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.

[2] Measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

[3] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

The following provider types are considered "specialty care" providers for purposes of BH I/DD Tailored Plan Time or Distance Standards for Medicaid and Appointment Wait Time Standards for Medicaid.

SPECIALTY CARE PROVIDERS FOR MEDICAID	
Reference Number	***Service Type***
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry
20.	Pulmonology
21.	Radiology
22.	Rheumatology
23.	Urology

BH I/DD TAILORED PLAN TIME OR DISTANCE STANDARDS FOR STATE-FUNDED SERVICES			
Reference Number	***Service Type***	***Urban Standard***	***Rural Standard***
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[1]	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
2	Location-Based Services	• Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Outpatient Program, Outpatient Opioid Treatment (OTP): ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients • Child and Adolescent Day Treatment Services: Not subject to standard	• Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Outpatient Program, Outpatient Opioid Treatment (OTP): ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients • Child and Adolescent Day Treatment Services: Not subject to standard
3	Crisis Services	• Facility based crisis for adults: The greater of: ° 2+ facilities within each BH I/DD Tailored Plan Region, OR ° 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available). • Non-Hospital Medical Detoxification: ≥ 2 provider within each BH I/DD Tailored Plan Region • Ambulatory Detoxification : ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region	
4	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5	Reserved		
6	Community/ Mobile Services	Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. High Fidelity Wraparound ≥ 2 provider within one hour	
6	Community/ Mobile Services	Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[2]	Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients

BH I/DD TAILORED PLAN TIME OR DISTANCE STANDARDS FOR STATE-FUNDED SERVICES			
Reference Number	***Service Type***	***Urban Standard***	***Rural Standard***
7	Residential Treatment Services	• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region • Substance Abuse Halfway House: ° Adult: Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[3] ° Adolescent: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • Substance Abuse Medically Monitored Community Residential Treatment: Access to ≥1 licensed provider • Substance Abuse Non-Medical Community Residential Treatment: ° Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department) ° Adolescent: Contract with all designated CASPs statewide ° Women & Children: Contract with all designated CASPs statewide • Substance Use Residential Supports & Mental Health Recovery Residential Services: To be determined * BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.	
8	Employment and Housing Services	• Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use): 100% of eligible recipients must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. • Individual Placement and Support-Supported Employment (Adult MH): 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • I/DD & TBI Day Supports. Community Living & Support, I/DD & TBI Residential Services, IDD Supported Employment: 100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan Region. • Clinically Managed Population-specific High Intensity Residential Programs: To be determined • TBI long-term residential rehabilitation services: To be Determined	

[1] The Department defines recipients for the purposes of network adequacy as those who received State-funded services during the previous year.

[2] The Department defines recipients for the purposes of network adequacy as those who received State-funded services during the previous year.

[3] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

PIHP TIME/DISTANCE STANDARDS		
Service Type	***Urban Standard***	***Rural Standard***
Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard
Location-Based Services	• Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment Program, Substance Abuse Intensive Outpatient Treatment Program, and Outpatient Opioid Treatment (OTR): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard	• Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment Program, Substance Abuse Intensive Outpatient Treatment Program, and Outpatient Opioid Treatment (OTR): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard
Crisis Services	• Professional treatment services in facility-based crisis program: The greater of: ° 2+ facilities within each PIHP Region OR ° 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimate) • Facility-based crisis services for children and adolescents: ≥ 1 provider within each PIHP Region • Non-Hospital Medical Detoxification: : ≥ 2 providers within each PIHP Region • Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal: ≥ 1 provider of each crisis service within each PIHP Region • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard	
Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP Region	
Partial Hospitalization	≥ 1 provider of each Partial Hospitalization within 30 minutes or 30 miles of residence for at least 95% of members	≥ 1 provider of each Partial Hospitalization within 60 minutes or 60 miles of residence for at least 95% of members
Community/ Mobile Services	100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
1915 (i) HCBS	Community Living & Support, Individual and Transitional Support, Respite and Supported Employment (for IDD and MH/SUD): ≥ 2 providers of each (i) Option service within each PIHP Region	

PIHP TIME/DISTANCE STANDARDS		
Service Type	***Urban Standard***	***Rural Standard***
Residential Treatment Services	• Residential Treatment Facilities Services: access to ≥ 1 licensed provider per PIHP Region • Substance Abuse Medically Monitored Supervised Residential Treatment: access to ≥ 1 licensed provider per PIHP Region (refer to 10A NCAC 27G.3400) • Substance Abuse Non-Medical Community Residential Treatment: ° Adult: Access to ≥ 1 licensed provider per PIHP Region (refer to licensure requirements to be determined by the Department) ° Adolescent: Contract with all designated CASPs within the PIHP's Region ° Women & Children: Contract with all designated CASPs within the PIHP's Region • Substance Abuse Halfway House: ° Adult: Access to ≥ 1 male and 1 female program per PIHP Region (refer to 10A NCAC 27G. 5600)[6] ° Adolescents: Access to ≥ 1 program per PIHP Region (refer to 10A NCAC 27G. 5600) • Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID): Not subject to standard	
1915 (c) HCBS Waiver Services: NC Innovations	• Community Living & Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each PIHP Region • Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each PIHP Region • Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard	

[6] PIHPs must also ensure that gender non-conforming members have access to substance use halfway house services.

Trillium is also required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service, see the tables on the following pages for both Medicaid, Medicaid-Direct, and State-Funded Services.

Providers are responsible for notifying Trillium if they are unable to meet the appointment wait time standards.

APPOINTMENT WAIT TIME STANDARDS FOR MEDICAID	
Visit Type	***Standard***
Primary Care	
Preventive Care Service—adult, 21 years of age and older	Within thirty (30) calendar days
Preventive Care Services—child, birth through 20 years of age	Within fourteen (14) calendar days for member less than six (6) months of age Within thirty (30) calendar days for members six (6) months or age and older.
After-Hours Access—Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) calendar days
Prenatal Care	
Initial Appointment—1st or 2nd Trimester	Within fourteen (14) calendar days
Initial Appointment—high risk pregnancy or 3rd Trimester	Within five (5) calendar days
Specialty Care	
After-Hours Access—Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) calendar days
Behavioral Health, I/DD, and TBI Services	
Mobile Crisis Management Services	Within two (2) hours
Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days
Routine Services for SUD Services	Within forty-eight (48) hours

APPOINTMENT WAIT TIME STANDARDS FOR STATE-FUNDED BH/IDD SERVICES	
Visit Type	***Standard***
Mobile Crisis Management Services	Within two (2) hours
Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non- Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days
Routine Services for SUD Services	Within forty-eight (48) hours

APPOINTMENT WAIT TIME STANDARDS FOR PIHP	
Visit Type	***Standard***
Behavioral Health and I/DD Services	
Mobile Crisis Management	Within two (2) hours
Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days
Routine Services for SUD Services	Within forty-eight (48) hours

Annual Network Adequacy Analysis

The Annual Network Adequacy Analysis is an annual evaluation of the Trillium catchment area including Medicaid members, Medicaid Direct members, and State-funded recipients that provides the opportunity to reveal where there may be gaps in services and opportunities to enhance access to services supporting diversity and inclusion. The purpose of the assessment is to develop and manage a qualified provider network in accordance with community needs. Trillium reviews all services, including crisis services, and identifies service needs and will prioritize strategies to address any network needs identified. Upon completion of the annual analysis, Trillium creates a Network Development Plan in order to mitigate any deficiencies. The Network Development Plan includes identification and analyses of gaps and requests for approval of exceptions. Trillium is contractually required to meet the exception process Trillium may utilize existing approved statewide alternative service definitions or develop and request approval for new alternative service definitions to fill network adequacy and accessibility service needs not met with current service definitions. Services reported under alternative service definitions may be used to support performance measures, while non-UCR services cannot.

J. BILLING, CLAIM EDITING, SNIP EDITING AND CLEARINGHOUSE REQUIREMENTS

FINANCE & CLAIMS DEPARTMENTS

The Finance Department manages the financial resources of the Tailored Plan. This includes management of fund sources and provider payment, ensuring compliance with General Statute 159 (The Local Government Fiscal Control Act) and other general accounting requirements. All providers are required to participate in Direct Deposit. The Claims Department supports providers with claims submission training and questions through its Claims Specialists. Refer to the billing guides for Carolina Complete Health for physical health claims and the Pharmacy Benefit Manager Provider Manual for pharmacy claims.

If you do not know who your claims specialist is, you can refer to the Trillium Claims Caseload Provider Split found on our website under Provider Documents.

All Trillium claims are submitted electronically. Providers can send standard HIPAA compliant transaction sets or use the Trillium web-based billing system and enter their claims directly or submit through one of Trillium's contracted clearinghouses.

ENROLLMENT AND ELIGIBILITY PROCESS

Eligibility Determination

Members who have their services paid for in whole or in part by Trillium must be enrolled in the Trillium system. Assistance is available in Provider Direct (PD) using Trillium Enrollment documentation. If you have any questions about a member's eligibility, please contact Trillium.

Members who are at 100% ability to pay according to the sliding fee schedule established by the provider or who have insurance coverage that pays 100% of their services, must not be enrolled in the Trillium system. However, the person may still receive and pay for services from a provider independent of Trillium involvement.

It is the responsibility of each provider to make a complete and thorough investigation of a member's ability to pay prior to requesting to enroll that person into the Trillium system.

This would require that the provider check for the following:

- Determine if the individual has Medicaid or whether the member may be eligible for Medicaid.
- Determine if the individual has Medicare or any other third-party insurance coverage.
- Determine if there is any other payer involved — worker's compensation, EAP program, court ordered services paid for by the court, etc.
- Determine if the individual meets Trillium criteria for use of Local or State Funds to pay for services. The criteria will be the lack of Medicaid or other third-party insurance and the inability of the member or family to pay for a portion of healthcare services based on the sliding fee schedule established by the provider.
- Determine if the individual has already been enrolled in the Trillium system.

If the individual has Medicaid or has already been enrolled in the Trillium system, she/he is financially eligible for Medicaid reimbursable services from Trillium. If they are not yet enrolled, then the provider must provide the data necessary to enroll the member. Enrollment can be performed electronically through the Provider Direct system or by contacting Trillium.

Providers should assist members who may be eligible for Medicaid funding in applying for Medicaid through their county Department of Social Services.

Key Data to Capture during Enrollment

All providers are required to ensure enrollment data is up-to-date based on the most current Trillium Enrollment Procedures and training.

Training documentation is found by logging into Provider Direct and clicking on Training Materials.

Submission of authorizations and claims prior to completing enrollment data will result in denials of authorizations and claims.

Third party insurance, including Medicare, must be included in the enrollment request. Medicaid members whose services will be paid in part by third-party insurance can be enrolled if Trillium is to be a secondary payor.

Effective Date of Enrollment

Enrollment in the Trillium system must be done prior to providing services except in emergency situations. It is the provider's responsibility to complete the eligibility determination process, including verification of previous enrollment in the Trillium system and to complete the enrollment process prior to providing services. Events with service dates prior to an enrollment date will be denied.

Crisis services provided in an emergency situation are an exception to this rule. In these cases, the provider must enroll the member within seven (7) days and indicate the date of enrollment as the date that the emergency services were provided.

Member ID

The Member ID number identifies the specific member receiving the service and is assigned by the Trillium information system. The member must be enrolled in the Trillium system to obtain this number. All claims submitted with incorrect Member ID numbers or for members whose enrollment is no longer active will be denied.

Eligibility Determination Process by Provider

Providers should conduct a comprehensive eligibility determination process whenever a member enters the delivery system. Periodically (no less than every 90 days), the provider should update eligibility information to determine if there are any first- or third-party payors for this member by completing a Client Update in the Provider Direct system. It is the provider's responsibility to monitor this information and to adjust billing accordingly.

Obligation to Collect

Providers must make good faith efforts to collect all first- and third-party funds prior to billing Trillium. First-party charges must be shown on the claim whether they were collected or not. The Trillium claims processing system has the ability to validate third-party payors and can deny or adjust the claim.

Reporting of Third-Party Payments

Providers must bill any third-party insurance coverage.

This includes worker's compensation, Medicare, employee assistance programs (EAPs), etc.

Providers are required to record on the claim either the payment or denial information from a third-party payor. Copies of the Electronic Remittance Advice (ERA), Explanation of Benefits (EOB) or CARC/RARC from the insurance company should be retained by the provider.

If an insurance company pays after a claim has been submitted to Trillium, the provider must notify and reimburse Trillium by submitting a replacement claim to reflect payment made by the third-party insurance.

Exceptions for TPL and Coordination of Benefits:

- Medical Support Enforcement: Services provided to members on whose behalf child support enforcement is being carried out if the third party coverage is through an absent parent
- Preventive Pediatric Services including early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Members entitled to one or more of the following programs or services:

SECTION V.I TABLE 1: Program and Service Exceptions for TPL and Coordination of Benefits

Program of Service	*Federal*	*State*
1. Crime Victims Compensation Fund	X	
2. Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
3. Ryan White Program	X	
4. Indian Health Services	X	
5. Veteran's Benefits for state nursing home per diem payments	X	
6. Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility	X	
7. Older American Act Program	X	
8. World Trade Center Health Program	X	
9. Grantees under the Title V of the Social Security Act	X	
10. Division of Service for the Blind		X
11. Division of Public Health "Purchase of Care" Program		X
12. Vocational Rehabilitation Services		X
13. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

Process to Modify

If there are known changes to the member's/recipient's income or family status, the provider is required to update records and adjust the payment amount based on the sliding fee schedule established by the provider. Members who become Medicaid eligible are not subject to sliding fee schedules for Medicaid covered services and payments should be adjusted immediately when this is determined.

At least on a quarterly basis (90 days), the member's/recipient's ability to pay should be verified and adjustments made by completing a Client Update in the Provider Direct system as necessary.

The sliding fee schedules are managed by providers and first party liability must be reported on claims. This compliance issue will be audited.

Sliding Fee Schedules

Eligibility for Benefit Determination

All members/recipients must be evaluated at the time of enrollment on their ability to pay. This determination should be updated at least every 90 days to ensure compliance with the sliding fee schedule established by the provider.

Process to Establish the Sliding Fee

Prior to being entered in the Trillium system, each member/recipient must have completed the financial eligibility process to establish any third-party coverage and to establish the ability to pay for services. The combination of a member's adjusted gross monthly income and the number of dependents determines the payment amount based on the sliding fee schedule established by the provider.

Medicaid members are not subject to sliding fee schedules for services paid for by Medicaid.

If a person does not qualify for the sliding fee schedule established by the provider, she/he should pay 100% of the services being provided. In this case, the person should not be enrolled in the Trillium system and claims should not be submitted to Trillium for reimbursement.

AUTHORIZATIONS REQUIRED FOR PAYMENT

System Edits

The Trillium information system is specifically designed to look for authorization data prior to paying claims. It has edits that are verified; therefore, the provider must be very attentive to what has been authorized to ensure maximum reimbursement.

Authorization Number and Effective Dates

Each authorization will have a unique number, a start date, and an end date. Only services with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.

Service Categories or Specific Services

Each authorization will indicate specific categories of services or in some cases very specific services that have been authorized. Each service will be validated against the authorization to make sure that the service matches the authorization. Services that are outside of these parameters will be denied.

Units of Service

Each authorization will indicate the maximum number of units of service that are being authorized. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits.

Providers need to establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.

Exceptions to Authorization Rule

There are certain services that will be paid without an authorization. These services are limited in scope and are limited in total number to a member, not to a provider. Once the annual limit has been reached for a member, then all services without an authorization, regardless of the provider of the service, will be

denied. Providers must be constantly aware of this issue in order to avoid denied claims.

CLEAN CLAIMS

A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. The term includes a claim with errors originating in the Tailored Plan's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud, waste or abuse, or a claim under review for medical necessity. A clean claim must meet timely filing guidelines.

Getting Paid—Clean Claims

Interest and penalty provisions for late or under-payments:

Any claim not paid within Timely Claim Payment limits will be subject to interest at the annual percentage rate of eighteen percent (18%). Interest is calculated for each calendar day after the date the clean claim should have been paid as specified in the contract between Trillium Health Resources and NCDHHS. In addition, Trillium Health Resources will pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the clean claim should have been paid as specified in the contract between Trillium Health Resources and NCDHHS.

Service Codes and Rates—Contract Provisions

All providers are reimbursed for approved services provided at the Trillium published rates unless otherwise stated in their contract. Providers must only use the service codes in their contract or reimbursement will be denied as non-contracted services. Providers can submit claims for more than the published rates, but only the published or contracted rate will be paid. If a provider submits a service claim for less than the published rate, the lower rate will be paid. It is the provider's responsibility to monitor the publishing of rates and to make the necessary changes to their billing systems. For providers who are subject to a rate floor, Trillium will pay the lesser of billed charges or the rate floor only if the provider has mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision.

State-Funded Recipients

State-funded recipients are not required to pay any copayments and providers are prohibited from requiring copayments.

Claims Submission Policy

Medicaid Direct and State-funded Services:

Providers who serve beneficiaries who are excluded or delayed populations from Medicaid managed care, will continue to receive behavioral health and I/DD services through Trillium Health Resources.

Providers have three ways to submit claims to Trillium using HIPAA Standard Electronic Transaction set:

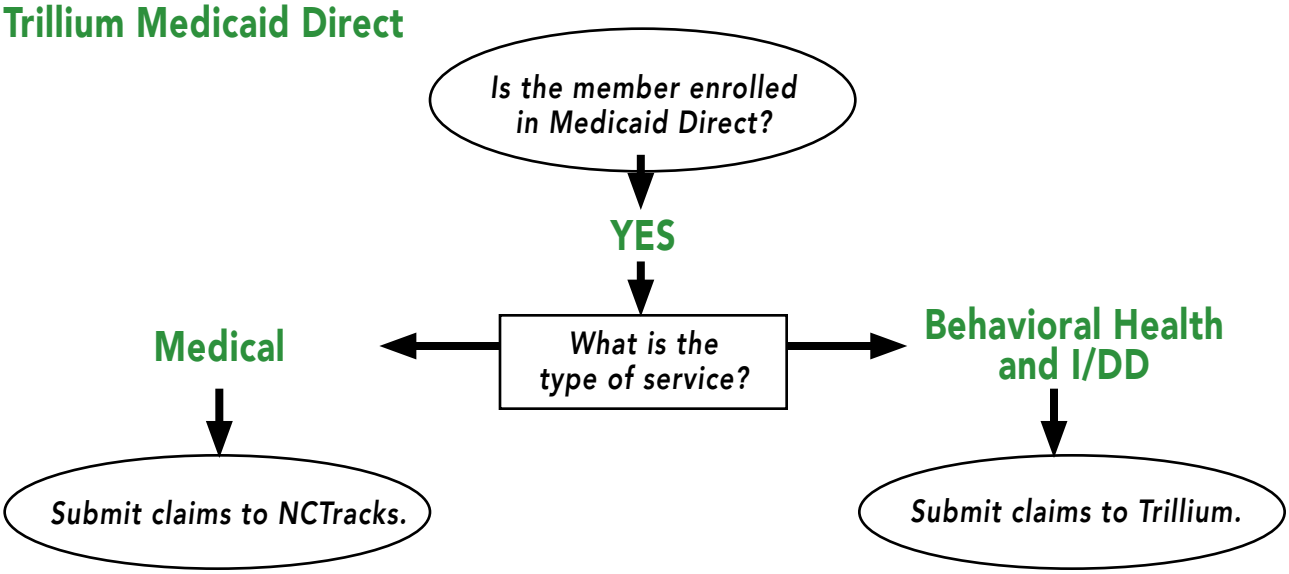
1. Through web portal in The Behavioral Health I/DD Secure Provider Portal—Provider Direct,
2. Via secure FTP, and
3. A provider can submit their claims through a clearinghouse

If submitting behavioral health and/or I/DD claims through a clearinghouse, Trillium has an agreement to utilize Change Healthcare (formerly known as Emdeon) and SSI Group. Trillium's Medical Payer ID is 43071 when using SSI Group or sending directly to Trillium, and 56089 when using Change Healthcare (Emdeon).

Services subject to Electronic Visit Verification (EVV) will need to be submitted through HHAeXchange. Trillium has partnered with an external vendor, HHAeXchange, to provide the EVV tools necessary for designated providers to comply and meet this requirement. General EVV information can also be found on the HHAeXchange North Carolina Provider Information Center.

For these beneficiaries, physical health and pharmacy claims will continue to be submitted to Medicaid Direct.

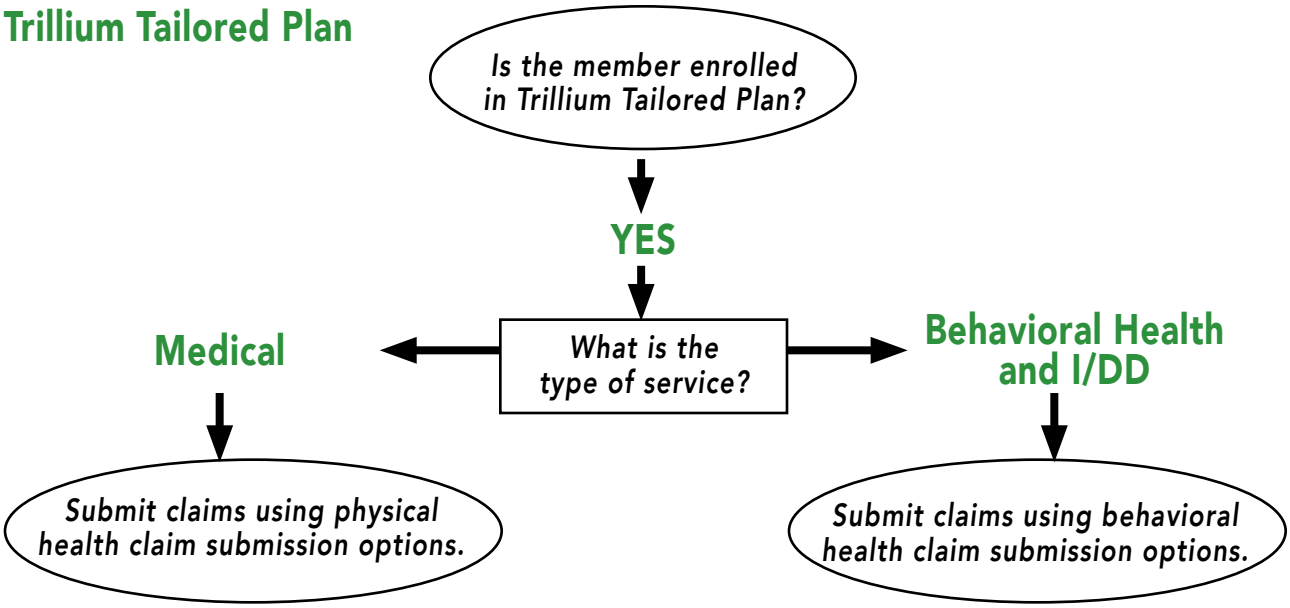
Trillium Medicaid Direct



Tailored Plan Medicaid

CLAIM SUBMISSION TABLE—REVISED OCTOBER 10, 2024		
Claims Submission Options	***Behavioral Health Claims***	***Physical Health Claims***
Direct Data Entry	Trillium's Provider Direct Portal	Trillium's Tailored Plan Physical Health Portal
Clearinghouse/SFTP	Behavioral Health claims can be submitted using one of two clearinghouses: • Change Healthcare • The SSI Group	Physical Health claims can be submitted through Availity
Payor ID	Change Healthcare: 56089 The SSI Group: 43071	68069
Paper Claims	Trillium Health Resources PO Box 240909 Apple Valley, MN 55124	Carolina Complete Health Attn: Claims PO Box 8003 Farmington, MO 63640-8003
Claims Submission Errors	Behavioral Health claims submitted to Physical Health processing system: *Explanation:* **EX1e—Deny: Please submit to Trillium for processing**	Physical Health claims submitted to Behavioral Health processing system: *Provider Portal:* Claim will receive error message upon attempt to submit of: **Please submit to CCH Tailored Plan Physical Health for processing** *EDI:* Claim will receive the following rejection message and be submitted to Physical Health system for processing: **Please submit to CCH Tailored Plan Physical Health for processing** *Processing:* **1371—Overrid-1377 Please submit to CCH Tailored Plan Physical Health for processing** **1377—Please submit to Carolina Complete Health for processing**

Trillium Tailored Plan



Note: This guidance is intended to assist providers in defining claims are considered behavioral health and is not an exclusive definition.

Emergency Department and Institutional Outpatient Claims

Emergency Department and Outpatient Hospital are defined as claims submitted with a revenue code 450-452,456,459, 900-910 or 912-918 with the primary/ principal diagnosis F01-F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89.

Professional Emergency Room Claims

Professional Emergency Room Claims billed with procedure codes 99281-99285, 99288 with the primary/ principal diagnosis F01-F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89 are considered BH Claims.

Inpatient Behavioral Health

Inpatient Behavioral Health claims are defined as claims submitted with a Behavioral Health DRG, MDC 19 and 20-DRG of '0880' THRU '0887', '0894' THRU '0897', '0876 or the claim contains one of the inpatients revenue codes listed below under the Exclusive Behavioral Health Revenue codes and does not have the billing provider taxonomy of 31400000X Nursing Home and without type of bill 66x (Intermediate Care Level II)

EXCLUSIVE BEHAVIORAL HEALTH REVENUE CODES			
Inpatient Room and Board			
Psychiatric		***Detoxification***	
0114	Private	0116	Private
0124	Semi-Private—Two Bed	0126	Semi-Private—Two Bed
0134	Semi-Private—Three and four Bed	0136	Semi-Private—Three and four Bed
0144	Private (Deluxe)	0146	Private (Deluxe)
0154	Ward	0156	Ward
0204	Intensive care		
Exclusive Psychiatric/Psychological Services Revenue Codes			
0900	General Psychiatric Treatment	0910	Reserved for National Use
0901	Psychiatric/Electroshock Treatment	0911	Psychiatric Residential Treatment Facility (PRTF)
0902	Milieu Therapy	0912	Partial Hospitalization
0903	Play Therapy	0913	Intensive Partial Hospitalization
0904	Activity Therapy	0914	Individual Therapy
0905	Intensive Outpatient Services—Psychiatric service	0915	Group Therapy
0906	Intensive Outpatient Services—Chemical dependency	0916	Family Therapy
0907	Community Behavioral Health Day Treatment	0917	Biofeedback
0908	Reserved for National Use	0918	Testing
0909	Reserved for National Use	0919	PRTF Crisis Assessment Program

- In addition, revenue codes from 101–182 and 184–219, 656 not listed above on the Exclusive Behavioral Health Revenue code list are considered Behavioral Health only when filed with a primary/principal diagnosis of F01-F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89 with the exception of Nursing Homes (taxonomy code 314000000X) or Bill Type 66X (Intermediate Care Level II). Nursing Home claims or Bill Type 66X is considered Physical Health.
- For Tailored Plan services, non-DPU providers submitting both Physical Health and Behavioral Health services on a single claim will be considered Physical Health claims.

Behavioral Health Procedure Codes—Professional Claims

Claims filed with the following exclusive procedure codes are defined as Behavioral Health Claims.

BEHAVIORAL HEALTH EXCLUSIVE LIST OF PROCEDURE CODES					
Psychiatric Diagnostic Evaluation, Psychotherapy, Medication Management, Crisis, and Psychological Testing CPT Code					
90785	90833	90840	90857	96112	96132
90791	90834	90845	90862	96113	96113
90792	90836	90846	90865	96116	96136
90801–90899	90837	90847	90870	96129	96137
90832	90839	90853	96110	96131	96139
Research-Based Behavioral Health Treatment (RB-BHT)					
97151	97152	97153	97154	97155	97156
97157					
Enhanced Mental Health and Substance Abuse Services					
H0004	H0015	H0036	H0046	H2017	H2034
H0010	H0019	H0038	H2011	H2020	H2035
H0012	H0020	H0040	H2012	H2022	
H0013	H0032	H0043	H2015	H2025	
H0014	H0035	H0045	H2016	H2033	
Personal Care, Day Care Service, Crisis Services, Telehealth					
S5102	S5145	T1005	T2016	T2027	T2038
S5110	S5150	T1023	T2020	T2029	T2041
S5111	S5165	T2013	T2021	T2033	
S5125	S9484	T2014	T2025	T2034	

Primary Care Physicians

Primary Care Physicians with the following taxonomy codes as billing or rendering taxonomy codes are considered Physical Health providers and should be submitted using the Physical Health Claim options listed in the previous table.

- 207Q00000X, 207QA0000X, 363LF0000X, 363LP2300X, 364SF0001X, 208D00000X, 207R00000X, 207RA0000X, 363LW0102X, 208000000X, 2080A0000X, 363LP0200X, 363LP1700X, 207QA0505X, 207QG0300X, 207RG0300X, 363A00000X, 363L00000X, 207VG0400X, 364S00000X, 363LA2200X, 363LG0600X, 364SG0600X, 207V00000X, 207VX0000X, 367A00000X, 363LX0001X

Behavioral Health and Physical Health Shared Procedure Codes

The following list of Procedure codes are considered Behavioral Health only when the Primary diagnosis is F01–F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89 or the Billing or Rendering Taxonomy code is listed on the Taxonomy Codes for Behavioral Health Providers table in the next section.

BEHAVIORAL HEALTH PROCEDURE CODES BASED ON PRINCIPAL DIAGNOSIS					
96105	99212	99238	99345	99422	B4100
96121	99213	99239	99347	99423	B4150
96127	99214	99242	99348	99441	B4152
96146	99215	99243	99349	99442	B4153
96372	99221	99244	99350	99443	B4154
98966	99222	99245	99360	99446	B4155
98967	99223	99252	99367	99447	B4157
98968	99231	99253	99406	99448	Q3014
99202	99232	99254	99407	99449	T1015
99203	99233	99255	99408	99492	T1019
99204	99234	99341	99409	99493	T1999
99205	99235	99342	99412	99494	
99211	99236	99344	99421		

Taxonomy Codes for Behavioral Health Providers

When a claim is filed with one of the following Behavioral Health Taxonomy codes in either the billing taxonomy code or the rendering taxonomy code the claim is considered a Behavioral Health Claim.

Behavioral Health Taxonomy Codes

FACILITY BASED TAXONOMY CODES	
251S00000X	Community/Behavioral Health
273R00000X	Psychiatric Unit
283Q00000X	Psychiatric Hospital
320800000X	Community Based Residential Treatment Facility—Mental Illness
323P00000X	Psychiatric Residential Treatment Facility (PRTF)
251C00000X	Day Training; Developmentally Disable Services
261QD1600X	Clinic/Center: Developmental Disabilities
261QR0405X	Clinic/Center; Rehabilitation; Substance Use Disorder
324500000X	Substance Abuse Disorder Rehabilitation Facility

BEHAVIORAL HEALTH AND SOCIAL SERVICES (BEGINS WITH 10)	
101YA0400X	Addiction (Substance Use Disorder) Counselor
101YM0800X	Mental Health Counselor
103K00000X	Behavioral Analyst
103T00000X	Psychologist
1041C0700X	Clinical Social Worker
106H00000X	Marriage and Family Therapist

ADVANCED PRACTICE NURSING PROVIDERS	
Nurse Practitioner	
363LP0808X	Psychiatric/Mental Health
Clinical Nurse Specialist	
364SP0807X	Psychiatric/ Mental Health; child & adolescent
364SP0808X	Psychiatric/ Mental Health
364SP0809X	Psychiatric/ Mental Health; adult
364SP0810X	Psychiatric/ Mental Health; child & family
364SP0811X	Psychiatric/ Mental Health; chronically ill
364SP0812X	Psychiatric/ Mental Health; community
364SP0813X	Psychiatric/ Mental Health; geropsychiatric

ALLOPATHIC & OSTEOPATHIC PHYSICIANS	
Psychiatry & Neurology	
2084A0401X	Addiction Medicine
2084P0802X	Addiction Psychiatry
2084P0804X	Child & Adolescent Psychiatry
2084N0600X	Clinical Neurophysiology
2084D0003X	Diagnostic Neuroimaging
2084F0202X	Forensic Psychiatry
2084P0805X	Geriatric Psychiatry
2084P0005X	Neurodevelopmental Disabilities
2084N0400X	Neurology
2080P0006X	Developmental Behavioral Pediatrics
2084N0402X	Neurology with Special Qualifications in Child Neurology
2084N0008X	Neuromuscular Medicine
2084P0800X	Psychiatry
2084S0012X	Sleep Medicine
2084V0102X	Vascular Neurology
2084P0015X	Psychosomatic Medicine

Electronic Visit Verification (EVV)

Services subject to Electronic Visit Verification (EVV) will need to be submitted through HHAeXchange. Trillium has partnered with an external vendor, HHAeXchange, to provide the EVV tools necessary for designated providers to comply and meet this requirement. General EVV information can also be found on the HHAeXchange North Carolina Provider Information Center, hhaexchange.com/nc/.

Pharmacy

Pharmacy claims are defined as those claims submitted for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims).

Pharmacy Point of Sale claims are processed through Trillium's partner, PerformRx and may be submitted electronically using the most current NCPDP HIPAA-approved format with Rx BIN Number 019595 and PCN—PRX10811.

NEMT/NEAT

Modivcare is Trillium's contractor to facilitate Non Emergency Medical Transportation (NEMT) and Non Emergent Ambulance Transportation (NEAT) services in North Carolina. Modivcare responsibilities include booking of reservations/rides and to process claims for NEMT/NEAT providers.

Providers can bill electronically through Modivcare's web portal, by an Automated Transportation Management System (ATMS), or by submitting paper claims. For any questions on how to bill, Providers should refer to Modivcare's Orientation and Training resources. For claims related questions, please contact Modivcare's Claims Department at **1-800-930-9060**. For any other Provider related questions specific to Modivcare rides, please contact: **1-855-397-3604**. Additional NC resources may be found in Transportation Provider Manual.

Vision

Vision claims for Medicaid Tailored Plan beneficiaries are processed through Centene Vision (formerly Envolve), a subsidiary of CCH and may be submitted using HIPAA Standard Electronic Transaction set or can be submitted in a secure web-based Provider Portal. Claims may also be submitted through a clearinghouse. Centene Vision utilizes the clearinghouse Change Healthcare. As long as the provider's clearinghouse has a connection to Change Healthcare, then the claim can be passed on to Centene Vision. Centene Vision's Payer ID is 56190.

Provider Portal Claims

The Behavioral Health I/DD Secure Provider Portal —Provider Direct and the Physical Health Secure Provider Portal are web-based systems available to Trillium providers upon completion of a Trading Partner Agreement (TPA).

Billing through the provider portals is Direct Data Entry (DDE) where an electronic CMS1500 or UB04 form is accessed and billing information is entered and submitted to for reimbursement. A direct link to these portals are found at Trillium's website under For Providers. The Behavioral Health I/DD Secure Provider Portal—Provider Direct Webinars are available in the Provider Direct Module to assist with completing a CMS1500 and UB04 claim form. In addition, CCH provider training resources can be found online.

Standard Codes for Claims Submission

Refer to the Trillium website for the following

- CPT/HCPCS/Revenue Codes
- Modifiers
- Diagnosis Codes
- Place of Service Codes

Payment of Claims and Claims Inquiries Providers must submit claims through Provider Direct or submit an electronic 837 file unless their contract specifically states an alternative method. Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule.

Formats

NC Innovations Services, Outpatient Therapy, Residential (state-funded) and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or the electronic CMS 1500 form if billing through the Provider Direct system.

Inpatient, Therapeutic Leave, Residential Services (Medicaid-funded), Outpatient Revenue Codes and ICF Services must be submitted using the ANSI 837I (Institutional) format or the electronic UB04 form if billing through the Provider Direct system.

Physical health claims can be submitted on CMS 1500 and CMS 1450 (UB-04). Professional providers and medical suppliers complete the CMS 1500 and institutional providers complete the UB-04 form.

Provider Direct Claims

Submission Providers are contractually required to submit billing electronically. Provider Direct is a web-based system available to Trillium providers upon completion of a Trading Partner Agreement (TPA.).

Billing through the Provider Direct system is Direct Data Entry (DDE) where an electronic CMS1500 or UB04 form is accessed, and billing information is entered and submitted to Trillium for reimbursement. Provider Direct webinars are available in the Provider Direct module to assist with completing a CMS1500 and UB04 claim form.

837 Claims Submission

Detailed instructions are provided in the Companion Guide, a user manual for electronic 837 submissions. The Companion Guide gives very specific instructions on what is required to submit claims electronically to Trillium.

The entire testing and approval process is covered in this document.

The HIPAA compliant ANSI transactions are standardized; however, each payer has the ability to exercise certain options and to insist on use of specific loops or segments. The purpose of the Companion Guide is to clarify those choices and requirements so providers can submit accurate HIPAA transactions.

Trillium will accept only HIPAA compliant transactions as required by law. Trillium provides the following HIPAA transaction files back to providers: 999 (an acknowledgment receipt) 824 (a line-by-line acceptance/rejection response), and 835 (an electronic version of the remittance advice.)

Providers Who Submit Paper Claims

Trillium does accept paper claims. All providers will be required to submit an accurate CMS1500 or UB04 billing form with the correct data elements.

A remittance advice will be provided by Trillium explaining payments and/or denials. Inquiries regarding the status of claims should be directed to the Trillium claims specialists.

Reimbursement Policy

Trillium's Reimbursement Policy along with the Claims Submission policy serves as a guide to help with accurate claim submissions for proper reimbursement.

All providers both participating and non-participating are reimbursed for approved services at the Trillium published rates unless otherwise stated in their contract.

If provider submits a service on the claim for less than the published rate, the lower rate will be paid. It is the provider's responsibility to monitor the publishing of rates and to make the necessary changes to their billing system.

For providers who are subject to a rate floor, Trillium will pay the lesser of billed charges or the rate floor only if the provider has mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision.

Providers will need to abide by their contract for billable CPT/HCPCS/Revenue Codes, Modifiers, Diagnosis codes and Place of Service codes.

With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997, Trillium is prohibited and does not appropriate funds for:

1. Causing or assisting in suicide, euthanasia, or mercy Killing.
2. Compelling any person or entity to provide or fund any item, benefit, program, or service for such purpose.
3. Asserting or advocating a legal right to cause or assist such actions.

Refer to the Trillium Website for the following:

- Rate Table

Trillium follows payment policies and applies edits.

The claims editing software application applies edits based on the following sources:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims
- CMS Claims Processing Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates
- CMS coding resources (HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claim Processing Manual, MLN Matters and Provider Transmittals AMA resources
- State-specific policies and procedures for billing professional and facility claims
- Trillium complies with SNIP editing validation requirements levels 1-5

Multiple Occurrences of Same Service in a Day

When a specific service is rendered multiple times in a single day, the service must be bundled and billed using multiple units rather than separate line items. This will prevent a duplicate billing denial.

Authorization

As described in the authorization and Authorization Process section of this manual, authorizations are for specific members/recipients, providers, types of services, date ranges, and for a set number of units. Providers are responsible for maintaining internal controls within their information systems to avoid a denial due to inconsistency with the authorization.

NPI (National Provider Identifier)

Providers are required to obtain an NPI number to submit billing on the CMS1500 and UB04 forms. The NPI number and taxonomy code are required for claims to be accepted and processed. Failure to comply with these guidelines will result in denied billing.

Billing a covered service does not guarantee reimbursement of a claim. The provider must follow proper billing and submission guides that have been provided in the claims submission policy. The services also have to be supported by medical records and meet medical necessity. If coding and billing guidelines are not followed then a claim could be rejected, denied, or payment recouped/recovered.

RESPONSE TO CLAIMS

Verification and Notification

Trillium provides the following response to ensure that electronic 837 billing is accepted into the Trillium system for processing payment:

- **999 X12 File**—This file acknowledges receipt of the 837 billing file.
- **824 X12 File**—This file provides feedback regarding whether line items in the 837 file have been accepted or rejected. If the line item has been rejected a detailed explanation will be provided.

These files are available in the File Repository option of the Provider Direct system. It is the provider's responsibility to review these responses to verify billing has been accepted for processing, so reimbursement is not interrupted due to file formatting issues.

Remittance Advice

The Remittance Advice is Trillium's way of communicating back to the provider network exactly how each and every service has been adjudicated. Trillium provides the Remittance Advice in the form of Adobe Acrobat (*.PDF) files. The Remittance Advice can be accessed through Provider Direct under the File Repository.

Electronic Remittance Advice (835)—for 837 Providers

HIPAA regulations require payors to supply providers with an electronic Remittance Advice known as the 835. The 835 will report electronically the claims status and payment information. This file is used by the provider's information system staff or vendor to automatically post payments and adjustment activity

to their member accounts. This allows providers the ability to manage and monitor their accounts receivables.

ACCOUNTS RECEIVABLE MANAGEMENT

Providers must take full responsibility for the management of their member accounts receivables. Trillium produces Remittance Advices based on the current check write schedule. Trillium produces a weekly claims status report in an Excel document format of cumulative processed claims for the current fiscal year.

Providers may select, sort and manage their billings, payments and denials. This file can be accessed through the provider's download file folder in Provider Direct.

KNOWN SYSTEMS ISSUES

Trillium maintains and shares a Known System Issues Tracker that informs providers on known health plan systems issues that may have an impact on providers. The tracker is updated on a weekly basis and shared with providers through Trillium's website under the For Providers tab.

CLAIMS INVESTIGATIONS—QUESTIONABLE BUSINESS PRACTICES

Trends of Use and Potential Fraud

One of the primary responsibilities of Trillium will be to monitor the provider network for fraud, waste and abuse. Both the Medicaid and State contracts make Trillium responsible for monitoring and conducting periodic audits to ensure compliance with all Federal and State laws and in particular the Medicare/Medicaid Fraud and Abuse laws. Specifically, Trillium will need to validate the presence of material information to support billing of services consistent with Medicaid and State regulations.

Trillium will systematically monitor the paid claims data to look for trends or patterns of abuse.

Audit Process

Trillium has the responsibility to ensure that funds are being used for the appropriate level and intensity of services as well as in compliance with Federal, State, and general accounting rules. The Trillium Provider Integrity (PI) Unit is responsible for billing audits for all contract providers.

Role of Finance Department

The Finance Department will assist the Program Integrity Unit with the review of financial reports, financial statements, and accounting procedures. The Finance Department will work with the Monitoring audit team and provider in the collection of any determined paybacks.

Voluntary Repayment of Claims

It is the provider's responsibility to notify Trillium in writing of any claims billed in error that will require repayment. To refund a claim to Trillium, the provider should complete either a replacement claim or void the claim. The adjustment will process and will appear on the next Remittance Advice. Instructions on how to complete an adjustment/void can be found on Trillium's website in the Provider Documents and Forms section under For Providers.

Reporting to State and Federal Authorities

For each case of reasonably substantiated suspected provider fraud, waste and abuse, Trillium is obligated to provide the Division of Health Benefits with the provider's name and number, the source of the complaint, the type of provider, the nature of the complaint, the approximate range of dollars involved and the legal and administrative disposition of the case.

REPAYMENT PROCESS/PAYBACKS

The Finance Department is responsible for the recovery of funds based on any audit findings.

Claims Investigation—Repayment Process/ Paybacks

Overpayment/Underpayment

Trillium Health Resources, to the extent required by Contract, promptly reports overpayments, specifying overpayments due to potential fraud in accordance with 42 C.F.R. §438.608(a)(2). Trillium Health Resources administers recovery of overpayment and underpayment in accordance with N.C. Gen. Stat. §58-3-225(h).

If Trillium determines a provider has:

- Failed to comply with State, Federal, Medicaid or any other revenue source requirements; or
- Been paid for a service or a portion of a service that should have been disallowed; or
- Been paid for a claim that was fraudulently billed, then Trillium will recoup the amount owed from current and/ or future claims. If payback amount exceeds outstanding provider claims, Trillium will invoice the provider the amount owed. The provider shall have 30 calendar days from the invoice date to pay back the total amount owed. 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 the provider never rendered or for which documentation is absent or inadequate. .

Trillium's responsibility to providers is to:

- Certify funding for all contracts in accordance with N.C.G.S. 159.
- Review and approve all financial commitments made by Trillium.
- Assign and monitor maximum funding for contracts notify providers, at least 30 calendar days in advance, of any changes in fee schedules or contract provisions monitor grant funds.
- Monitor retroactive Medicaid eligibility and recovery of funds manage claims processing and pay clean claims within prompt pay guidelines.
- Issue payments and Remittance Advices (RAs) on paid and denied claims recover funds based on audit findings.
- Audit providers for coordination of benefits.
- Investigate and respond to member grievances and complaints related to provider services.
- Review provider's documentation of complaints, grievances and their resolutions and to ensure providers incorporate these complaints into their QA/QI process.
- Determine when complaints should be forwarded to provider network for an investigation.
- Determine if complaints are substantiated, partially substantiated, unsubstantiated, resolved or unresolved.
- Ensure timeframes for scheduling member/recipient appointments are in compliance.
- Ensure provider agencies are in compliance with the "no wrong door" policy.
- Ensure providers do not take adverse actions against real or suspected complainant(s) and to clearly understand this activity will be acted upon by the Tailored Plan accordingly.
- Notify complainant and provider who disagrees with the results of the Tailored Plan action on complaints their appeal rights.
- Ensure complaints related to licensed facilities, use, neglect and exploitation, etc., are reported to the appropriate agencies, local Department of Social Services (DSS), Division of Health Service Regulations (DHSR), local police department, etc.
- To report and promptly return overpayments within sixty (60) days of identifying the overpayment.

K. CULTURAL AND LINGUISTIC COMPETENCY AND ACCESSIBILITY REQUIREMENTS

A primary focus of Trillium is to develop, implement and monitor processes that promote culturally competent and responsive care to members.

Trillium recognizes the cultural diversities woven through the communities we serve and strives to contract with providers who recognize that efficacious services requires meeting the unique cultural needs of our communities and the individuals who reside within them.

The past two decades have seen unprecedented demographic shifts nationally and in North Carolina. Increased diversity, both cultural and linguistic, has produced significant challenges for health care delivery systems. It is our responsibility to plan for, implement and deliver services that are culturally competent, member-focused and person-centered to an increasingly diverse community.

The fundamental precepts of cultural competency include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one's self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse members and communities.

A culturally competent approach to services requires the system examine and potentially transform each component of service delivery.

Trillium's Cultural Competency Plan was created in collaboration with the Provider Council. The plan can be found on the Trillium website under Provider Documents.

As a provider, the ability to understand, appreciate and interact effectively with members has a profound impact on the effectiveness of the healthcare provided. Members must be able to communicate symptoms clearly and understand the recommended treatment.

LIMITED ENGLISH PROFICIENCY, LIMITED READING ABILITY, IMPAIRED VISION, AND HEALTH LITERACY

It is important for anyone seeking services from a Trillium network provider to have meaningful access to those services. Accessibility involves more than getting into a building. It means being able to communicate effectively with the service provider in a way each recipient can easily understand.

Members and recipients who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can have limited English proficiency (LEP). This includes people who are deaf, hard of hearing, as well as those who speak a language other than English.

These members and recipients may be entitled to language assistance with respect to a particular type of service, benefit, or encounter. The General Conditions Contract stipulates that providers ensure compliance with all stated regulations, which includes Title VI of the Civil Rights Act of 1964. Compliance with Title VI involves the provision of linguistically and culturally appropriate services. Further, Title VI requires federally funded practitioners to make services linguistically accessible by providing free language assistance through translated materials, interpreters or bilingual staff. For LEP resources, see the Resources and Web Links page at the end of this manual.

L. CARE COORDINATION AND DISCHARGE PLANNING REQUIREMENTS

CARE COORDINATION AND CARE TRANSITIONS

For all members (regardless of whether or not a they choose to opt out of Care Management, does not engage in Tailored Care Management, or is ineligible for Tailored Care Management), Trillium as the Behavioral Health I/DD Tailored Plan will continue to support those members through care coordination and care transitions. Care Coordination will include support with obtaining and maintaining housing through dedicated housing specialists and providing access to medical-legal partnerships for legal issues pertaining to a member's health. Trillium will also address unmet health-related resource needs for those members not participating in Tailored Care Management.

Members who opt out of or never engage in Tailored Care Management will continue to receive oversight from Trillium to manage care transitions such as moving from one clinical setting to another. This is done to prevent readmissions to the hospitals or other higher levels of care, emergency department visits, and other potential adverse outcomes for members. Trillium will work with providers in our network to facilitate these transitions for our members not otherwise engage in Tailored Care Management.

Discharge Review

Discharge planning begins at the time of the initial assessment and is an integral part of every member's/recipient's treatment plan regardless of the level of care being delivered.

The discharge planning process includes use of the member's/recipient's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the member/recipient with functioning in the community.

Involvement of family members and other identified supports, including members of the medical community, require the member's/recipient's written consent. The purpose of this process is to identify the steps to be taken by the Utilization Management care manager in assisting with discharge planning efforts.

Discharge Process

The Utilization Management Care Manager reviews the status of the discharge plan at each review to assure that:

- A discharge plan exists.
- The plan is realistic, comprehensive, timely and concrete.
- Transition from one level of care to another is coordinated.
- The discharge plan incorporates actions to assure continuity of existing therapeutic relationships.
- The member/recipient understands the status of the discharge plan.
- When the discharge plan is lacking in any respect, the Utilization Management Care Manager addresses the relevant issues with the provider.
- The Utilization Management care manager assists with the development of discharge plans for members/recipients in all levels of care.

Among the functions:

- Identify members/recipients who are remaining hospitalized, or at any other level of care, who do not meet criteria for that level of care and help develop a plan to get the right service at the right level.
- Monitor members/recipients to assure that they receive clinically indicated services.
- Whenever a member/recipient is discharged from detoxification, inpatient psychiatric or partial hospitalization care, the discharge plan should include a follow-up appointment within seven (7) calendar days.

A Trillium representative will coordinate with the person's Clinical Home to ensure there are appropriate services in place following discharge. If the person does not have a Clinical Home, and the person meets Special Needs Population criteria, the care manager will refer to the Care Management Department for follow-up by a care manager.

M. DEPARTMENT-REQUIRED DOCUMENTATION REQUIREMENTS

MEMBER AND RECIPIENTS RECORDS REQUIREMENTS

Each provider must adhere to the regulations set forth for records compliance, including medical records. In efforts for the provider to render the highest quality healthcare service to members, providers must keep accurate and complete medical records. This will also enable Trillium Health Resources to review the quality and appropriateness of the services rendered. Each entity, including Trillium and service providers, owns the records they generate and bear responsibility for these records and they should be stored in a secure location.

Medical records refer to the complete, comprehensive member records including (but not limited to) x-rays, laboratory tests, results, examinations, assessments and notes, accessible at the site of the beneficiaries participating primary care physician or provider, documenting all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable State and federal rules and regulations, and signed by the medical professional rendering the services.

Applicable state and federal rules and regulations for complete clinical records are set forth by NCDHHS Records Management and include but may not be limited to:

- NCGS 121 and 132
- 45 CFR 164
- 42 CFR Part 2
- APSM 45-1: Confidentiality Rules
- APSM 45-2: Records Management and Documentation Manual for Providers
- APSM 30-1: Rules for MH/DD/SAS Facilities and Services
- APSM 10-5: Records Retention and Disposition Schedule for Providers
- APSM10-6: Records Retention and Disposition Schedule for Health Plans
- NCTracks Provider Claims and Billing Assistance Guide
- NC Clinical Coverage Policies
- NC Innovations Technical Guide

Upon closure of a provider's network operations, non-renewal of contract or termination of the contract regardless of the reason the provider may submit a plan for maintenance and storage of all records for approval by Trillium. When submitting a plan for maintenance, Providers should include a Record Retention Log that includes: provider name, provider address, and phone number, total number of records involved, agency contact person, procedure for requesting records, member/recipient name, member/ recipient record number, member/recipient date of birth, date of last service, and type of services provided. The Record Retention Log is on the Trillium website under Provider Documents & Forms.

Plan for maintenance and log should be sent to:

Trillium Health Resources
Attention: Medical Records
144 Community College Road
Ahoskie, NC 27910
or MedicalRecords@TrilliumNC.org

Trillium has the sole discretion to approve or disapprove of this record retention plan. If disapproved, Trillium may ask the provider for copies of all member/recipient records served under the contract to be delivered to Trillium within sixty (60) days.

N. PROVIDER APPEALS AND GRIEVANCE PROCESS

Determination and Notification of Actions Taken Against Network Providers

Generally, sanction recommendations are reviewed by the Trillium Sanctions Committee. The Committee may determine to impose a sanction or to use a corrective action based on the evidence, and/or significance and nature of the violation.

The network provider will be notified, in writing, within thirty (30) calendar days of Trillium 's invocation of the disciplinary action process.

Written communication will include, as applicable:

- The right to submit additional information.
- The right to request an appeal regarding the decision within established timeframes and the right to request an extension of established timeframes for showings of good cause.

Provider Appeals

In order to respect providers, protect members/recipients, and satisfy our contractual obligations, Trillium maintains a formal mechanism for the resolution of provider appeals. This Appeals Process is available to any network provider who wishes to initiate it when Trillium takes an adverse action against them and/or suspends their participation in Trillium provider network.

Appeals to Trillium are available to a network provider for the following reasons:

- Program integrity related findings or activities.
- Finding of fraud, waste, or abuse by Trillium.
- Finding of or recovery of an overpayment by Trillium.
- Withhold or suspension of a payment related to fraud, waste, or abuse concerns.
- Termination of, or determination not to renew, an existing contract for LHD care/care management services.
- Determination to de-certify an AHM+ or CMA.
- Violation of terms between Trillium and the provider.

Out-Of-Network Providers may appeal certain actions taken by Trillium.

Appeals to Trillium are available to an out-of-network provider for the following reasons:

- An out-of-network payment arrangement.
- Finding of waste or abuse by Trillium.
- Finding of or recovery of an overpayment by Trillium.

Providers must submit a formal written request for an appeal within thirty (30) calendar days from when the provider receives written notice informing them of the action, or BH-I/DD Tailored Plan should have taken a required action and failed to take such action. Trillium allows providers to submit written appeal requests through Trillium's online provider portal, Provider Direct, or by mailing a certified copy of the request to

Trillium Health Resources
Attn: Appeals Department
201 West First Street
Greenville, NC 27858

The request should include the date the appeal is being requested, a detailed description of the provider's position with respect to the Trillium action giving rise to the provider's right to appeal, and any supporting documentation. If a provider mails in the certified appeal, it must submit supporting documentation that includes protected health information on a HIPAA-compliant flash drive in PDF format.

Trillium can extend the timeframe by which it accepts a written request for an appeal from a provider by thirty (30) calendar days for good cause, with the existence of good cause being determined by Trillium. In order to request a good-cause extension of the timeframe by which a provider would otherwise be required to submit its appeal, a provider must submit a written request to Trillium, either through Provider Direct or by mail, that includes the date of the request, the reason the provider is of the opinion that good cause for

extension exists and any supporting documentation that addresses the issue of good cause. Providers must submit a written request for a good-cause extension within thirty (30) calendar days from when the provider receives written notice from Trillium of the decision giving rise to the right to appeal.

Trillium's decision shall be considered final if a provider's appeal request is not received within thirty (30) calendar days of receiving written notice informing the provider of the action.

Trillium's provider appeals process offers an opportunity for providers to share information that they feel is pertinent to their appeal request. Trillium does not discriminate or retaliate against any provider based on any action taken by that provider in exercising its appeal rights. Trillium allows providers to be represented by an attorney during the appeals process. Trillium requires that providers exhaust Trillium's internal appeals process before seeking a recourse under any other process permitted by contract or law.

The network provider who requests an appeal has the burden of proof to establish that the adverse action should be reversed or modified.

Upon receipt of a properly and timely submitted provider appeal request, Trillium's Provider Appeals Coordinator categorizes the appeal request as a claims appeal, an adverse action appeal or a withhold or suspension of payment appeal. Trillium acknowledges receipt of each appeal request within five (5) calendar days of receipt of the request.

CLAIMS APPEALS

In addition to the appeal categories described above, all providers have the right to file claims appeals. A claims appeal concerns Trillium's denial, in whole or in part, of a payment for service.

When providers receive a claims denial from Trillium, the provider's Remittance Advice ("RA") Form will include instructions on how to file a claims appeal and the deadline to do so.

The provider appeal coordinator decides claims appeals based upon written information and documentation contained in the provider's appeal request and upon written information and documentation provided by Trillium's Claims Department.

Trillium provides written notice of decision of a claims appeal within thirty (30) calendar days of receiving a claims appeals request. This written notice will include information regarding further appeal rights, if and as applicable.

APPEALS OF SUSPENSION OR WITHHOLD OF PROVIDER PAYMENT

Trillium limits the issue on appeal in cases of suspension or withhold of provider payment to whether Trillium had good cause to commence the withhold or suspension of provider payment. In such appeals, Trillium does not address whether the provider has or has not committed fraud, waste or abuse.

Trillium notifies the Department within ten (10) business days of a suspension or withhold of provider payment.

Trillium offers providers the option for an in-person or telephone hearing when the provider is appealing whether Trillium has good cause to withhold or suspend payment to the provider.

Trillium schedules a hearing and issues a written decision regarding whether Trillium had good cause to suspend or withhold payment within fifteen (15) business days of receiving the provider's appeal. Upon a finding that Trillium did not have good cause to suspend or withhold payment, Trillium reinstates any payments that were withheld or suspended within five (5) business days.

ADVERSE ACTION APPEALS

Upon receipt of a written request for an appeal of an adverse action, Trillium's Provider Appeals Coordinator will notify the Trillium department that issued the adverse action that gave rise to the appeal. The applicable Trillium department will then designate a

departmental representative to compile all available information, including any summaries of his/her own research, if applicable. The designated representative shall be expected to represent Trillium's position throughout the appeal process.

During the appeal process, the network provider and Trillium departmental representative will have an allotted timeframe to present their evidence.

Except as otherwise approved by the appeals coordinator, the network provider shall have up to one hour to make its presentation, and the presentation of information will proceed as follows:

1. Trillium's departmental representative presentation
2. Network provider presentation
3. Rebuttal of network provider's presentation
4. Surrebuttal of Trillium's rebuttal

The network provider may submit additional information that it deems relevant to the appeal request no less than five (5) business days prior to the panel meeting. The provider appeals coordinator will submit any information used by the departmental representative to the network provider, upon request. The network provider is not permitted to submit additional information after the meeting has occurred. In all cases, minutes of the proceedings are kept and are made available to the network provider, upon written request.

The the appeal panel, which consists of at least three (3) qualified individuals who were not involved in the original decision, is convened by the Provider Appeals Coordinator. The appeal panel includes an external peer reviewer.

The panel will carefully review the information submitted for the appeal, with particular attention given to the information submitted by the network provider and then, by majority vote, make a decision to uphold, overturn, or modify the adverse action.

The provider appeals coordinator will draft the written notification of the panel's decision and send it to the network provider via certified mail, return receipt requested, within thirty (30) calendar days from Trillium's receipt of the request for appeal. The appeal resolution letter will include information about the provider's right to further appeal (as appropriate) and the deadline and mechanism to request such an appeal.

Grievances & Complaints

A **grievance** is defined as any expression(s) of dissatisfaction about any matter other than an Adverse Benefit Determination (see definition of action below) filed by a member or by an individual who has been authorized in writing to file on behalf of a member. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The resolution of a grievance may be appealed.

If a grievant wishes to appeal the resolution of a grievance, the grievant must request an appeal within sixty (60) calendar days of the mailing date of the grievance resolution letter. Trillium does not discriminate or retaliate against an individual for filing a grievance or requesting a grievance appeal.

Complaint is defined as an expression of dissatisfaction about any matter other than an utilization review decision by a recipient or a recipient's authorized representative (including legal guardian or provider) who has written consent to act on behalf of the recipient.

Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's or recipient's rights. The resolution of a complaint may be appealed. The complaint resolution letter will inform the complainant of the deadline to appeal. Trillium does not discriminate or retaliate against any individual for filing a complaint or requesting a complaint appeal.

Trillium allows providers to submit complaint through Trillium's on-line provider portal, Provider Direct, or by mailing a copy of the request to: Trillium Health Resources, 201 W 1st Street, Greenville, NC 27858, or by calling the Provider Support & Service Line.

Adverse Benefit Determination means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of a Health Plan or PIHP to act within the timeframes provided in the Federal Regulations
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financials liabilities.
- The denial of a Medicaid member's request to exercise his or her right, to obtain services outside the network but only if the member lives in a rural area and there is no Trillium network provider who is available to provide the service.

Trillium takes an omni-channel approach to accepting complaints and grievances, so providers, members, recipients, stakeholders or anyone else may choose their preferred method of engagement. We accept complaints and grievances verbally, electronically or in writing. If an individual requests to have a complaint or grievance filed anonymously, all reasonable efforts will be made to protect their identity and Trillium will provide safeguards for protecting the individual from harassment or retaliation. Our "no wrong door" policy allows any Trillium staff to accept and file a complaint or grievance on behalf of anyone.

The available channels include:

- Member and Recipient Services
- Provider Support Service Line

- Trillium Website
- Trillium Provider Direct Portal
- NCDHHS
- Certified Mail
- Secure Emails

Trillium maintains a formal process to manage complaints and grievances through a centralized, coordinated process. Regardless of how it is submitted, the grievance or complaint submitted is documented and acknowledged by Trillium via letter.

If the issue is not something Trillium has oversight of, Trillium will make a referral to the appropriate agency, which could be, but is not limited to, the Department of Social Services, Division of Health Service Regulations, Division of Mental Health/Developmental Disabilities/Substance Abuse services.

Grievances are resolved within 30 calendar days of receipt. Trillium may extend the timeframe for resolution by up to 14 calendar days if the member/ recipient requests the extension or if the Plan shows there is need for additional information and how the delay is in the member's/recipient's best interest. If the Plan extends the timeframe, it must, for any extension not requested by the member/recipient, give the member/ recipient written notice of the reason for the delay.

Once Trillium has completed its investigation of a grievance, Trillium will send a standardized resolution letter to the person who filed t grievance and all other parties involved in the review. Per contractual requirements, providers are required to cooperate fully with all investigative requests, including but not limited to, immediate access to any of the contractual locations/sites, where services are provided to members/recipients, in addition to any site where financial or clinical records are maintained. Failure to do so may be grounds for contract termination.

Trillium resolves complaints within 15 business days from receipt or within 30 calendar days from receipt, depending on whether Trillium conducts an informal or formal investigation of the complaint. Trillium sends a standardized resolution letter to complainants.

If a provider wishes to issue a complaint about Trillium Health Resources' business operations, they may contact the Provider Ombudsman for support in submitting their complaint via the contact channels below:

Provider Ombudsman
Email Medicaid.
Medicaid.ProviderOmbudsman@dhhs.nc.gov
Provider Ombudsman
Phone 1-866-304-7062

O. COMPLAINT OR GRIEVANCE INVESTIGATION AND RESOLUTION PROCEDURES

GRIEVANCE & COMPLAINT PROCESS INTERNAL TO CONTRACTED NETWORK PROVIDERS

All contracted network providers must have a grievance/ complaint process to address any concerns of the member or recipient and the family related

to the services provided. The provider must keep documentation on all grievances received, including date received, points of grievances, and resolution information. Any unresolved concerns or grievances should be referred to Trillium's Complaints & Grievances Unit.

Upon enrollment and upon request, the grievance/ complaint process must be shared with all members, recipients and families. The provider must advise members, recipients and families that they may contact Trillium directly about any concerns or grievances.

Trillium's Member and Recipient Services line—1-877-685-2415—must be published and made available to all members, recipients and family members in the provider's office.

Additionally, other agencies available to take grievances/complaints must be posted. These agencies include Division of MH/DD/SAS Member Care Line, 1-919-733-7011, in Raleigh and Disability Rights NC, 1-877-235-4210.

P. PERFORMANCE IMPROVEMENT

i. Surveys

An important aspect of our quality program and the services provided to members are surveys and member experience. Feedback through surveys is obtained from members, practitioners/providers, community stakeholders, family members, etc. at least annually.

Trillium encourages providers and members to participate in any and all surveys, as these are opportunities for providers and members to share feedback with Trillium. There are a number of surveys administered throughout the year. For additional details, a description of each is included below.

Surveys cover the following areas:

- Services provided and our network of behavioral health care practitioners and providers
- Ease of accessibility to our staff and our network providers
- Availability of appropriate types of behavioral health practitioners, providers and services
- Acceptability (about cultural competence to meet member needs)
- Claims processing
- Utilization management process
- Coordination of care
- Member and Provider Satisfaction

Providers are required to participate in the survey process upon receiving notification from Trillium. We truly appreciate the time our providers take to assist with administration of these surveys. The feedback we receive from providers is invaluable. Responses received have shaped our current roles/responsibilities in developing a collaborative partnership between Trillium and providers.

Trillium's Quality Management department is committed to sharing information with our members, families and network about our quality activities and initiatives. Trillium shares results of Member Experience Surveys with members, families, and the network by posting results on our website and sharing with various committees including the Global Quality Improvement, Consumer Family Advisory Committees (CFACs), and the Provider Council.

Trillium requires a contact person for all surveys be identified. Please submit your point of contact for all surveys and their contact information to Surveys@TrilliumNC.org.

Member Satisfaction Survey

The Division of Health Benefits (DHB) conducts an annual satisfaction survey for all Medicaid members. DHB contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess member satisfaction with services. The instrument selected for the survey is a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) determined by NCDHHS. This is a member satisfaction survey as well as a major component of Healthcare Effectiveness Data and Information Set (HEDIS). The CAHPS® survey is a measurement tool, used for all products, which ask members to report and evaluate their experiences with health care in areas of customer service, access to care, claims processing and provider interactions. The survey sample includes adult Medicaid recipients over age 18, and parents or guardians of child Medicaid recipients between age 12 and 17 who received mental health, substance use, or intellectual/developmental disabilities services through the Tailored Plan within the last year. The survey is administered over a 12-week period using a mixed-mode (mail and telephone) protocol.

The three-wave protocol consists of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing to non-respondents, and finally a phone follow-up to non-respondents for whom a valid telephone number is available.

Providers should encourage members to complete these surveys. Once complete, results of the survey are returned to Trillium Health Resources for analysis, review, and any corrective action if deemed necessary.

National Core Indicator (NCI) Survey

NCI surveys are administered annually by the NC Division of MH/DD/SAS with assistance from the Carolina Institute for Developmental Disabilities (CIDD) and the University of NC at Chapel Hill. The NCI survey collects information from people with disabilities and their families and guardians to find out what service areas are working well and what areas may need improvement in North Carolina and nationally.

NC DHHS provides the random sample of members to be interviewed both in person and via mail. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.

Perceptions of Care Survey

The NC Division of MH/DD/SAS conducts a Perceptions of Care survey on an annual basis to assess members' perception of care of services received from network providers for mental health or substance use services. A designated number of members are selected to participate in the survey. A team of Quality Management Department staff provide member surveys and, if needed, assist with survey administration. Once the designated number of surveys is completed, the surveys are returned to DMH/DD/SAS for analysis.

Once analysis by DMH/DD/SAS is complete, results of the survey are returned to Trillium for internal analysis, review, and determination of any corrective action if deemed necessary. The Perceptions of Care survey is administered to a random selection of members each year.

Provider Satisfaction Survey

Provider Satisfaction Surveys are administered annually to providers to allow the Division of Health Benefits (DHB) to assess the Tailored Plan/PIHP's ability in the following three areas:

1. Interacting with their network providers
2. Providing training and support to their providers
3. Providing Medicaid waiver materials to help their providers strengthen their practice

The instrument selected for the survey is provided by DHB. Active providers are surveyed for their opinions of satisfaction with Trillium. An active provider is defined as a Medicaid provider that has at least five encounters within the previous six months. The survey is administered over a six-week period using a web survey protocol.

Once complete, results of the survey are returned to Trillium for analysis, review, and any corrective action if deemed necessary.

ii. Clinical Studies

Actively participate in member/recipient satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements.

iii. Incident Reporting

Member health and safety along with quality of care are priorities for Trillium. Monitoring and promoting member/ recipient health and safety is integrated throughout many activities, including incident reporting. Incidents and potential quality of care concerns are tracked and monitored for trends, areas needing immediate attention or opportunities for improvement.

Providers of publicly funded services licensed under NC General Statutes 122C, AND providers of publicly funded non-licensed, periodic mental health, developmental disabilities and/or substance abuse services are required to complete and report incidents for members/recipients receiving mental health, developmental disabilities and/or substance abuse services. Private independent practitioners, clinicians,

and hospitals are not required to report through the Incident Response Improvement System (IRIS) system, as they follow their own reporting guidelines. These reports must not be filed in the member record but must be filed on site for review during any type of local monitoring by the Tailored Plan.

As part of its quality management process, it is important for the provider to implement procedures that ensure the review, investigation and follow up for each incident that occurs through its own internal Quality Management process.

This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns.
- Strategies aimed at the reduction/elimination of trends and patterns.
- Documentation of the efforts of improvement as well as an evaluation of ongoing progress.
- Adherence to mandatory reporting requirements.
- Entry of Level II and III incidents into the state's Incident Response Improvement System (IRIS).

There are specific state laws governing the reporting of abuse, neglect or exploitation of members/recipients. It is important that the provider's procedures include all of these requirements.

If a report alleges the involvement of a provider's staff in an incident of abuse, neglect or exploitation, the provider must ensure that members are protected from involvement with that staff person until the allegation is substantiated or unsubstantiated. The provider must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

Trillium is required to monitor certain types of incidents that occur with providers in its network, as well as providers who, while not in Trillium's network, operate services in one of the counties Trillium covers.

Regulations regarding Trillium's monitoring and the classification of incidents (Level I, II, or III) as well as requirements related to the submission of incident reports to home and host Tailored Plan and state agencies can be located in North Carolina Administrative Code. Trillium is required to monitor the state IRIS system. QM staff review all incidents when received by Trillium for completeness, appropriateness of interventions, achievement of short- and long-term follow-up both for the individual member, as well as the provider's service system. If questions/concerns are noted when reviewing the incident report, the Quality Management Coordinator will work with the provider to resolve them. If issues/concerns are raised related to member care, services, or the provider's response to an incident, QM staff may elect to refer the concerns to the Network Department to further investigate. On a daily basis, QM staff track and report specific category types of Level II and III incidents. This information is shared within Trillium to assess if there is any immediate action needed due to health and safety concerns. Providers that fail to report incidents as required by Administrative Rule and the provider contract may be required to complete a Plan of Correction.

An incident is any happening which is not consistent with the routine operation of a facility or service or the routine care of a member and that is likely to lead to adverse effects upon a member. There are three levels of response to incidents (Level I, Level II, Level III) based on the potential or actual severity of the event.

It is strongly encouraged that each provider read the NC Incident Response Improvement System (IRIS) manual available on the NCDHHS website for further information and clarification. In addition, Trillium has provided an in-depth training related to IRIS and Incident Reporting that can be located on Trillium's "My Learning Campus". Trillium's QM Department will provide additional training as needed and when there are changes to any guidelines or processes.

Level I Incidents

These incidents are events that, in isolated numbers, do not significantly threaten the health or safety of an individual, but could indicate systematic problems if they occur frequently. Level I Incidents require routine care. Level I incidents should be reported to the appropriate clinical staff involved in the care of the individual. These reports must not be filed in the member record but be filed on site for review during local monitoring.

Level II Incidents

These incidents are a threat to a member's/recipient's health or safety or a threat to the health or safety of others due to:

- **Death**: Terminal illness or other natural cause (must be listed as such on a death certificate or member is receiving hospice).
- **Restrictive Intervention**: Any emergency, unplanned use or planned use of restrictive intervention that exceeds authorized limits, is administered by an unauthorized person or results in discomfort, complaint or requires medical treatment
- **Consumer Injury**: Any injury that requires treatment by a medical professional beyond First Aid. Car accidents that occur while member is receiving services from the provider.
- **Abuse/Neglect/Exploitation**: Any allegation of abuse by family, peers, or strangers that requires a report to law enforcement and/or DSS.
- **Medication Error**: Error that threatens an individual's health or safety, as determined by a physician and/or pharmacist.
- **Consumer Behavior**: Suicidal behavior not resulting in death or permanent damage; Inappropriate sexual behavior, Aggressive behavior, Destructive behavior and/or Illegal behavior involving a report to law enforcement or complaint to an oversight agency or a potentially serious threat to the health or safety of self or others; and Consumer Absence greater than 3 hours or requiring police contact.
- **Suspension**: Any provider withdrawal of services for one day or more due to the member's/recipient's misconduct.
- **Expulsion**: Any permanent provider withdrawal of services due to the member's/recipient's misconduct.
- **Fire**: Any fire that threatens health or safety of the member/recipient or others.

These reports are to be entered into the IRIS website within seventy-two (72) hours of the learned incident. These incidents must also be reported to the appropriate clinical staff involved in the care of the member/recipient.

These reports must not be filed in the member's/recipient's record but must be able accessible for review during local monitoring.

Level III Incidents

These incidents are defined as any happening, which is not consistent with the routine operation of a facility or service or the routine care, that is likely to lead to adverse effect and result in:

- Death due to suicide, violence/homicide, accident, unknown cause, or occurring within 7 days of seclusion or restraint.
- Any action that results in death, permanent physical or psychological impairment, or if the incident is perceived to be a significant danger to or concern of the community.
- Sexual assault/rape, sexual abuse, or permanent physical impairment or psychological impairment to a member/recipient or caused by a member/recipient.
- A substantial risk of death or permanent physical impairment or psychological impairment to a member/recipient or caused by a member/recipient.
- A threat caused by a member/recipient to a person's safety.
- An allegation of Abuse/Neglect/Exploitation by a provider staff member.
- A report to the media, Amber/Silver Alert.

For Level III incidents, the provider must verbally or electronically notify Trillium within twenty-four (24) hours and must enter a report in IRIS within seventy-two (72) hours of the learned incident. (Exception: allegations of abuse/neglect/exploitation by staff must be reported to HCPR within twenty-four (24) hours via IRIS). Deaths within seven (7) days of a restrictive intervention must be reported verbally and entered into IRIS immediately.

For Level III incidents that occur while the member/recipient is receiving a service or that occurred on the provider's premises, the provider must convene an Internal Review Team within 24 hours of the incident. Trillium requires all Network Providers to have a process in place enabling them to identify when a Level III incident has occurred and how to conduct a detailed investigation of the event/incident.

The internal review team shall review the member/recipient record, gather additional information if needed, and enter a report in IRIS concerning the incident and notify any other authorities required by law (DSS, law enforcement, DJJ, etc.). The report to the North Carolina Health Care Personnel Registry (for allegations against staff) is completed through IRIS and must be entered within 24 hours of learning of the incident.

The provider must resubmit the IRIS report within 5 working days regarding the results of their investigation. Trillium monitors the provider's progress to ensure that the above process is being adequately implemented.

These reports must not be filed in the member/recipient record but must be filed on site for review during monitoring visits.

Back-Up Staffing Reports

Providers are required to submit back-up staffing reports for all Innovations members when there is a deviation in the member's staff coverage schedule. "Failure to Provide Back-Up Staffing" forms must be completed when back-up staffing is not available (i.e., staff is out sick, on extended leave, had an appointment, on vacation, resigned, terminated, did not show to work) or when back up-staffing is offered but declined by the member/guardian.

Please note that service breaks do not require back-up staffing reports; service breaks are defined as holidays, family vacations, weather conditions, member illnesses, and scheduling conflicts. The reports must be submitted to Trillium bi-monthly. Hours missed from the first to the 15th of the month are due by the 22nd of that month. Hours missed from the 16th to the end of the month are due by the 7th of the following month. Reports must be submitted to the Quality Management Department at IncidentReporting@TrilliumNC.org, or via fax at 252-215-6880.

Restrictive Interventions

There are two types of restrictive interventions:

Planned Interventions

- If there is a therapeutic need for a member/recipient to have hands on intervention or other rights' restrictions as ongoing interventions (4 or more incidents within 30 days), it must be included as an addendum to the person-centered plan. This addendum must be signed by a psychologist (PhD) or medical doctor (MD) in addition to the person-centered plan.
- It is also required to have the provider's Human Rights Committee and guardian approval prior to implementation. These restrictive intervention plans may be requested by Trillium staff for submission and review.
- If the member/recipient has a planned intervention as part of their documented treatment plan and is not injured during the intervention then this is considered a Level I incident. It is the expectation that these Level I incidents be reported to the appropriate clinical staff.

Emergency Interventions

- Not planned, are not part of the person-centered plan and have not been approved for use by a Human Rights Committee.
- Planned, but administered improperly or without proper authorization, by staff without proper training, or for longer than the authorized time.
- Planned, but resulting in discomfort, complaint, death or injury requiring treatment by a licensed healthcare professional.

Emergency Interventions are considered level II incidents and must be reported within seventy-two (72) hours of the incident via IRIS.

Restrictive Interventions Reporting Requirements in a PRTF Setting

All restrictive interventions that occur in a Psychiatric Residential Treatment Facility (PRTF) are not considered planned interventions even with an approved behavior plan. PRTFs are prohibited from using any standing, "as needed" or "PRN" order for restraint or seclusion. Therefore, all restrictive interventions in a PRTF setting are considered emergency interventions and are required to be entered into the IRIS system.

QM 11—In Subsection (e) of Rule 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers, Category A (licensed) and Category B (non-licensed) providers are required to report a summary of Level I, II and III incidents to the Plan each quarter on the QM-11 Form. Trillium requested a waiver of this requirement. **Therefore, providers do not have to complete the QM11 reports.** The QM11 report requirement has been waived.

iv. Outcomes Requirements

CONTINUOUS QUALITY IMPROVEMENT

The QM department supports a global continuous quality improvement model that includes all network providers and practitioners. Continuous Quality Improvement (CQI) activities are designed to promote the highest quality care for physical health, behavioral health, intellectual and/or developmental disabilities, traumatic brain injury, and Long-Term Services and Supports needs. Trillium's Quality Management and Improvement Program (QMIP) takes a data driven, outcome-based approach to quality.

Quality Improvement initiatives are designed to provide support to practitioners/providers to achieve quality goals at the regional and practice level.

The QMIP promotes objective and systemic measurement, monitoring, evaluation and improvement of whole person care and services.

Trillium's quality improvement philosophy is based on the continuous quality improvement model which involves a process of design, discovery, remediation, and improvement.

This model includes:

- A process for implementing appropriate remedial action for continuous quality improvement.
- A structured and systematic approach to identify quality improvement opportunities.
- A common language for problem solving techniques.

- Facilitation of communication among groups.
- Provides supports for the basis quality value of managing by data.
- An increase in the credibility of data and reproducibility.

The design, discovery, remediation and improvement model is a process to identify and implement strategies and improvement activities. CQI is best envisioned as a cyclical process, one component feeding into the next.

Design

The designing and incorporation of quality and improvement strategies into the structures and processes of the organization.

Discovery

Evaluate data, identify opportunities for improvement, and identify appropriate intervention strategies based on best practices and known barriers.

Remediation

Implement program(s) to address identified needs and barriers.

Improvement

Measure the effects of the improvement program and assess its effectiveness. Continue intervention if effective. Adjust as necessary to achieve goal targets. Repeat cycle if intervention does not achieve desired result.

At its core, CQI is a team process. It is the responsibility of each individual to be an active and contributing member of the team. Each member participating on a workgroup, committee, or as part of a team, brings a unique perspective to the process; i.e., how things work; what happens when changes are made, and how to sustain improvements during daily work. Focus is on the team component of the principles because as an organization we are all interdependent.

Data is an important cornerstone of quality improvement. Data is used to describe how well current systems are working; what happens when changes are applied, and to document successful performance.

PDSA, which stands for plan, do, study, act, is a continuous quality improvement process used as a framework for problem solving and performance improvement. PDSA is a four-step process for carrying out change that is utilized by Trillium. Just as a circle has no end, the PDSA cycle should be repeated again and again for continuous improvement.

The Plan-Do-Study-Act Process:

1. **Plan**: Recognize an opportunity, identify a project and plan a change.
2. **Do**: Gather data to test the change. Carry out a small-scale study.
3. **Study**: Review the test, analyze and study the data, and identify what you've learned. Determine if performance goals were met or not. If they were met, move to the final phase.
4. **Act**: Take action based on what you learned in the study step. If the change did not work, go through the cycle again with a different plan. If you were successful, incorporate what you learned from the test into wider changes. Use what you learned to plan new improvements, beginning the cycle again.

Trillium values and expects providers to perform continual self-assessment of services and operations, as well as develop and implement plans to improve member outcomes.

Network providers are required to be in compliance with all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the provider contract. The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider's improvement system, as well as systems used to assess services, plans for improvement and their effectiveness will be evaluated by Trillium.

PROVIDER PERFORMANCE IMPROVEMENT PROJECTS

A Performance Improvement Project (PIP) is an initiative to measure and improve the service and/or care provided by an organization. Quality measures are used to improve services by monitoring and analyzing data and modifying practices in response to this data.

Providers should demonstrate a Continuous Quality Improvement (CQI) process by identifying and maintaining PIPs throughout the year. Most often, initiatives or activities are selected based on data that indicates a need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Trillium recommends providers complete PIPs that demonstrate evidence of performance improvement related to some aspect of organizational processes/ structure, member outcomes, or other provider improvement activities.

PIPs are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these activities/studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service.

Technical Assistance can be provided upon request.

For further information regarding PIPs please reference the training provided on the Provider.MyLearningCampus.org related to PIP's.

HIPAA Incident Reporting

Providers should adhere to regulations regarding HIPAA standards. In the instance of a HIPAA breach/ violation, Trillium should be notified within 72 hours of the occurrence. All potential HIPAA violations/ breaches should be reported in the EthicsPoint system. EthicsPoint can be accessed through the Trillium website. Providers must comply with the Breach Notification Rule requirements following a breach of unsecured protected health information.

NORTH CAROLINA TREATMENT AND OUTCOMES PROGRAM PERFORMANCE SYSTEM (NC-TOPPS)

The program by which the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services measure the quality of substance abuse and mental health services and their impact on members' lives. Please review all details and NC-TOPPS requirements in the manual.

Online interviews conducted at initiation, three months, six months, twelve months, biannually and at the end of an episode of care provide information on each member's service needs and outcomes. The responsibility for completing the NC-TOPPS interviews are determined by a hierarchy of services based on age-disability. Priority for the responsible provider agency is in hierarchical order so that if a consumer is receiving two or more of the required services during a given period, the service that is in the highest order on the table is responsible for the NC-TOPPS. See the hierarchy outlined in the NC-TOPPS Guidelines.

The initial interview must be completed with the member at the beginning of an episode of care during the first or second visit. The Update Interviews (3, 6, and 12 months and biannual or twice a year) are to be submitted within the appropriate time frame as long as the member is receiving treatment.

If the member is no longer receiving the qualified treatment, an Episode Completion is submitted. The NC-TOPPS must be administered by a Qualified Professional.

For more information on submitting the NC-TOPPS or for training, you may contact the Network Management Department at NCTOPPS@TrilliumNC.org. The agency will monitor the compliance of providers in its network. Providers who fail to meet the benchmark established by the agency will be issued Plans of Correction.

NC-SNAP REQUIREMENTS

All members who receive I/DD services must have an NC-SNAP administered at least annually. An NC-SNAP is not required for those members that have an approved Support Intensity Scale (SIS) assessment for Innovation Waiver services or an approved 1915i assessment for 1915i services. Members who receive Innovation Waiver services are required to receive a SIS completed every 2 years for children ages 5-15 ½ years old and every 3 years for adults beginning at the age of 15 ½. Members who are approved and receive 1915i services are required to receive a 1915i assessment annually or sooner if circumstances or needs change.

- NC-SNAP Assessments will be completed in accordance with protocols specified in the NC-SNAP Examiner's Guide.
- All NC-SNAP Assessments are required to be completed by a Certified NC-SNAP Examiner.

NC-SNAP EXAMINER CERTIFICATION TRAINING

NC-SNAP Certification is only available to those staff with the appropriate credentials who are in a position that requires them to complete or review NC-SNAP Assessments as part of their job responsibilities. Typically, this is a Qualified Professional.

To request NC-SNAP Training, please complete the NC SNAP Examiner's Training Registration Form and the NC SNAP Eligibility Determination Form and email them to NCSNAP@trilliumnc.org. Please Note: Each of these forms must be completed electronically.

The NC SNAP Examiner's Training Schedule, Training Registration Form, and Eligibility Forms are located on the NCDHHS website.

Trillium is responsible for ensuring that all providers submit the NC-SNAP Assessment annually as part of the Performance Contract with the Department of Health and Human Services which is monitored by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

For additional information about the NC-SNAP, visit the state's NC-SNAP website. For Trillium-related questions regarding NC SNAP, email NCSNAP@TrilliumNC.org.

GPRA CORE CLIENT OUTCOME MEASURES FOR DISCRETIONARY SERVICES PROGRAMS

All providers receiving State Opioid Response (SOR) funding are required to complete the Government Performance and Results Act (GPRA) Core Client Outcome Measures for Discretionary Services Programs tool as required by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Any individual receiving new substance use specific treatment service and who is eligible for the Adult Substance Opioid Use Disorder (ASOUD) Benefit Plan is required to be assessed using this tool.

The GPRA Assessment Tool, along with the Instruction Guide, and FAQ are available on Trillium's website.

Please review details and additional requirements.

Q. COMPENSATION AND CLAIMS PROCESSING REQUIREMENTS

i. Requirement Electronic Formats

Trillium operates a secure web-based module called Provider Direct, which is the exclusive web portal for contracted network providers to enroll new individuals, search for members, update member information, submit treatment authorization requests (TARs), view authorization letters, and submit claims for processing.

Providers must have a login and password to use Provider Direct. If your agency already has a system administrator for Provider Direct, please contact that person to be assigned a login. If your agency is new to Trillium and doesn't have a system administrator for Provider Direct, someone at your agency should be designated as the system administrator for Provider Direct and follow the process outlined in the Accessing Provider Direct Instructions.

Providers may elect to submit their claims using the HIPAA Standard Electronic Transaction Set.

Medicaid Direct Services and State Funded Services

Providers who serve beneficiaries who are excluded or delayed populations from Medicaid managed care, will continue to receive Behavioral Health and I/DD services through Trillium Health Resources.

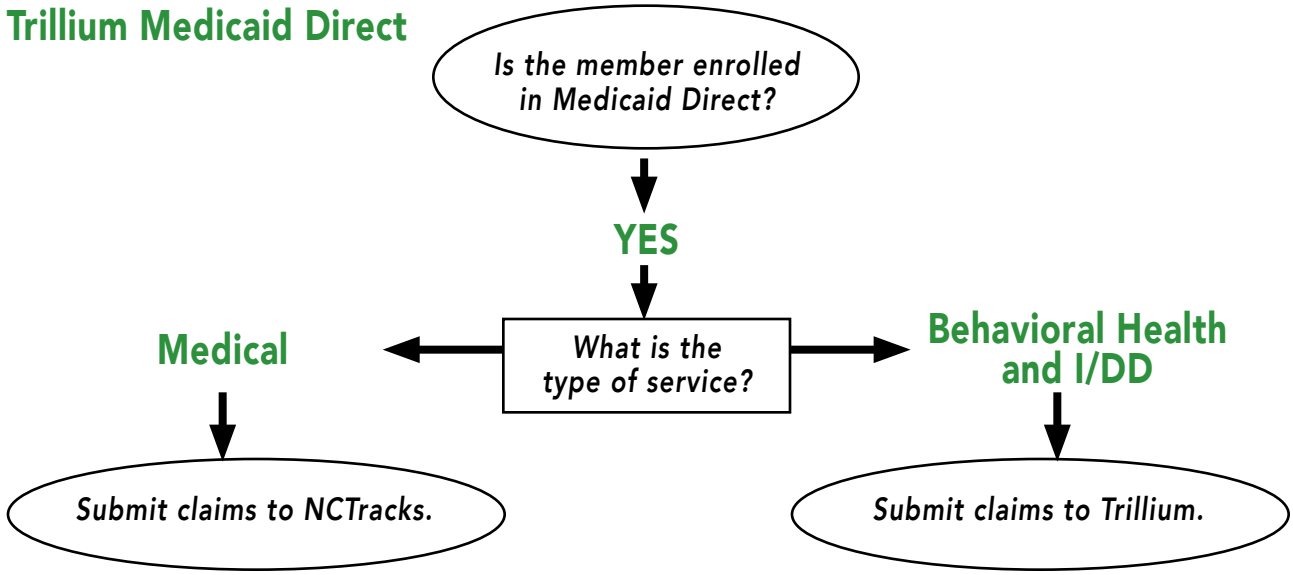
Providers have three ways to submit claims to Trillium using HIPAA Standard Electronic Transaction set:

1. Through web portal in The Behavioral Health I/DD Secure Provider Portal—Provider Direct,
2. Via secure FTP, and
3. A provider can submit their claims through a clearinghouse

If submitting Behavioral Health I/DD claims through a clearinghouse, Trillium has an agreement to utilize Change Healthcare formerly known as Emdeon and The SSI Group. Trillium's Medical Payer ID is 43071 when using The SSI Group or sending directly to Trillium and 56089 when using Change Healthcare (Emdeon).

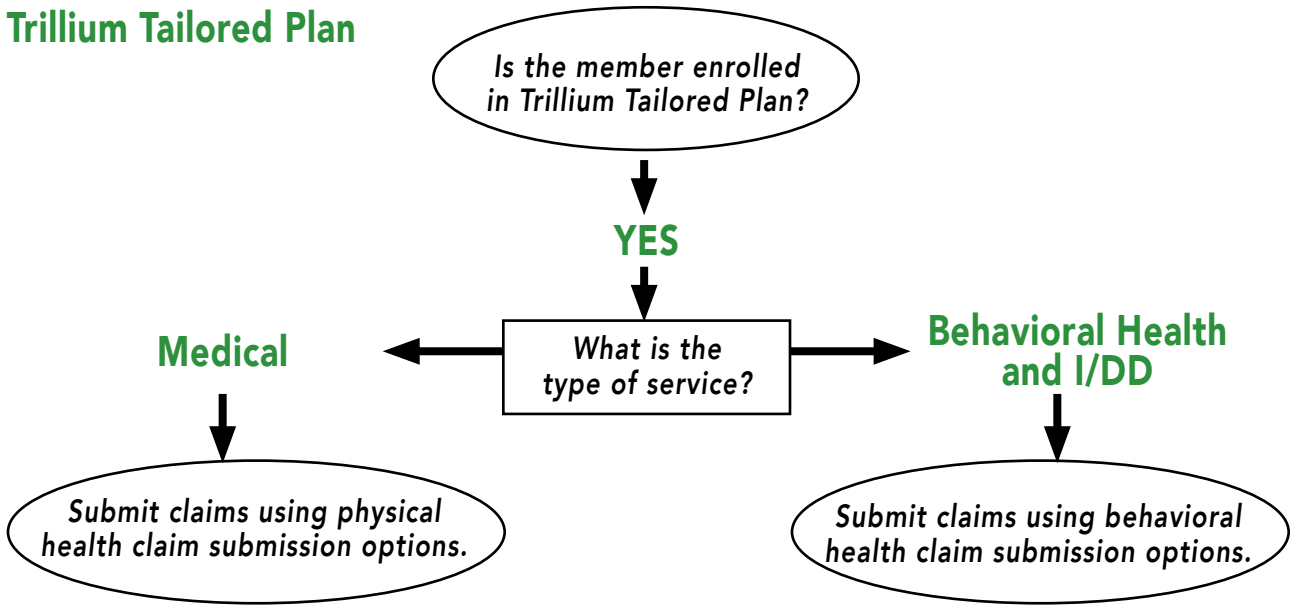
Services subject to Electronic Visit Verification (EVV) will need to be submitted through HHAeXchange. Trillium has partnered with an external vendor, HHAeXchange, to provide the EVV tools necessary for designated providers to comply and meet this requirement. General EVV information can also be found on the HHAeXchange North Carolina Provider Information Center.

For these beneficiaries, physical health and pharmacy claims will continue to be submitted to Medicaid Direct.



Tailored Plan Medicaid

CLAIM SUBMISSION TABLE—REVISED OCTOBER 10, 2024		
Claims Submission Options	***Behavioral Health Claims***	***Physical Health Claims***
Direct Data Entry	Trillium's Provider Direct Portal	Trillium's Tailored Plan Physical Health Portal
Clearinghouse/SFTP	Behavioral Health claims can be submitted using one of two clearinghouses: • Change Healthcare • The SSI Group	Physical Health claims can be submitted through Availity
Payor ID	Change Healthcare: 56089 The SSI Group: 43071	68069
Paper Claims	Trillium Health Resources PO Box 240909 Apple Valley, MN 55124	Carolina Complete Health Attn: Claims PO Box 8003 Farmington, MO 63640-8003
Claims Submission Errors	Behavioral Health claims submitted to Physical Health processing system: *Explanation:* **EX1e—Deny: Please submit to Trillium for processing**	Physical Health claims submitted to Behavioral Health processing system: *Provider Portal:* Claim will receive error message upon attempt to submit of: **Please submit to CCH Tailored Plan Physical Health for processing** *EDI:* Claim will receive the following rejection message and be submitted to Physical Health system for processing: **Please submit to CCH Tailored Plan Physical Health for processing** *Processing:* **1371—Overrid-1377 Please submit to CCH Tailored Plan Physical Health for processing** **1377—Please submit to Carolina Complete Health for processing**



Note: This guidance is intended to assist providers in defining claims are considered behavioral health and is not an exclusive definition.

Emergency Department and Institutional Outpatient Claims

Emergency Department and Outpatient Hospital are defined as claims submitted with a revenue code 450-452,456,459, 900-910 or 912-918 with the primary/ principal diagnosis F01-F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89.

Professional Emergency Room Claims

Professional Emergency Room Claims billed with procedure codes 99281-99285, 99288 with the primary/ principal diagnosis F01-F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89 are considered BH Claims.

Inpatient Behavioral Health

Inpatient Behavioral Health claims are defined as claims submitted with a Behavioral Health DRG, MDC 19 and 20-DRG of '0880' THRU '0887', '0894' THRU '0897', '0876 or the claim contains one of the inpatients revenue codes listed below under the Exclusive Behavioral Health Revenue codes and does not have the billing provider taxonomy of 31400000X Nursing Home and without type of bill 66x (Intermediate Care Level II)

EXCLUSIVE BEHAVIORAL HEALTH REVENUE CODES			
Inpatient Room and Board			
Psychiatric		***Detoxification***	
0114	Private	0116	Private
0124	Semi-Private—Two Bed	0126	Semi-Private—Two Bed
0134	Semi-Private—Three and four Bed	0136	Semi-Private—Three and four Bed
0144	Private (Deluxe)	0146	Private (Deluxe)
0154	Ward	0156	Ward
0204	Intensive care		
Exclusive Psychiatric/Psychological Services Revenue Codes			
0900	General Psychiatric Treatment	0910	Reserved for National Use
0901	Psychiatric/Electroshock Treatment	0911	Psychiatric Residential Treatment Facility (PRTF)
0902	Milieu Therapy	0912	Partial Hospitalization
0903	Play Therapy	0913	Intensive Partial Hospitalization
0904	Activity Therapy	0914	Individual Therapy
0905	Intensive Outpatient Services—Psychiatric service	0915	Group Therapy
0906	Intensive Outpatient Services—Chemical dependency	0916	Family Therapy
0907	Community Behavioral Health Day Treatment	0917	Biofeedback
0908	Reserved for National Use	0918	Testing
0909	Reserved for National Use	0919	PRTF Crisis Assessment Program

- In addition, revenue codes from 101–182 and 184–219, 656 not listed above on the Exclusive Behavioral Health Revenue code list are considered Behavioral Health only when filed with a primary/principal diagnosis of F01-F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89 with the exception of Nursing Homes (taxonomy code 314000000X) or Bill Type 66X (Intermediate Care Level II). Nursing Home claims or Bill Type 66X is considered Physical Health.
- For Tailored Plan services, non-DPU providers submitting both Physical Health and Behavioral Health services on a single claim will be considered Physical Health claims.

Behavioral Health Procedure Codes—Professional Claims

Claims filed with the following exclusive procedure codes are defined as Behavioral Health Claims.

BEHAVIORAL HEALTH EXCLUSIVE LIST OF PROCEDURE CODES					
Psychiatric Diagnostic Evaluation, Psychotherapy, Medication Management, Crisis, and Psychological Testing CPT Code					
90785	90833	90840	90857	96112	96132
90791	90834	90845	90862	96113	96113
90792	90836	90846	90865	96116	96136
90801–90899	90837	90847	90870	96129	96137
90832	90839	90853	96110	96131	96139
Research-Based Behavioral Health Treatment (RB-BHT)					
97151	97152	97153	97154	97155	97156
97157					
Enhanced Mental Health and Substance Abuse Services					
H0004	H0015	H0036	H0046	H2017	H2034
H0010	H0019	H0038	H2011	H2020	H2035
H0012	H0020	H0040	H2012	H2022	
H0013	H0032	H0043	H2015	H2025	
H0014	H0035	H0045	H2016	H2033	
Personal Care, Day Care Service, Crisis Services, Telehealth					
S5102	S5145	T1005	T2016	T2027	T2038
S5110	S5150	T1023	T2020	T2029	T2041
S5111	S5165	T2013	T2021	T2033	
S5125	S9484	T2014	T2025	T2034	

Primary Care Physicians

Primary Care Physicians with the following taxonomy codes as billing or rendering taxonomy codes are considered Physical Health providers and should be submitted using the Physical Health Claim options listed in the previous table.

- 207Q00000X, 207QA0000X, 363LF0000X, 363LP2300X, 364SF0001X, 208D00000X, 207R00000X, 207RA0000X, 363LW0102X, 208000000X, 2080A0000X, 363LP0200X, 363LP1700X, 207QA0505X, 207QG0300X, 207RG0300X, 363A00000X, 363L00000X, 207VG0400X, 364S00000X, 363LA2200X, 363LG0600X, 364SG0600X, 207V00000X, 207VX0000X, 367A00000X, 363LX0001X

Behavioral Health and Physical Health Shared Procedure Codes

The following list of Procedure codes are considered Behavioral Health only when the Primary diagnosis is F01–F99.99, T14.91XD, T14.91XS, T14.91XA and R45-R45.89 or the Billing or Rendering Taxonomy code is listed on the Taxonomy Codes for Behavioral Health Providers table in the next section.

BEHAVIORAL HEALTH PROCEDURE CODES BASED ON PRINCIPAL DIAGNOSIS					
96105	99212	99238	99345	99422	B4100
96121	99213	99239	99347	99423	B4150
96127	99214	99242	99348	99441	B4152
96146	99215	99243	99349	99442	B4153
96372	99221	99244	99350	99443	B4154
98966	99222	99245	99360	99446	B4155
98967	99223	99252	99367	99447	B4157
98968	99231	99253	99406	99448	Q3014
99202	99232	99254	99407	99449	T1015
99203	99233	99255	99408	99492	T1019
99204	99234	99341	99409	99493	T1999
99205	99235	99342	99412	99494	
99211	99236	99344	99421		

Taxonomy Codes for Behavioral Health Providers

When a claim is filed with one of the following Behavioral Health Taxonomy codes in either the billing taxonomy code or the rendering taxonomy code the claim is considered a Behavioral Health Claim.

Behavioral Health Taxonomy Codes

FACILITY BASED TAXONOMY CODES	
251S00000X	Community/Behavioral Health
273R00000X	Psychiatric Unit
283Q00000X	Psychiatric Hospital
320800000X	Community Based Residential Treatment Facility—Mental Illness
323P00000X	Psychiatric Residential Treatment Facility (PRTF)
251C00000X	Day Training; Developmentally Disable Services
261QD1600X	Clinic/Center: Developmental Disabilities
261QR0405X	Clinic/Center; Rehabilitation; Substance Use Disorder
324500000X	Substance Abuse Disorder Rehabilitation Facility

BEHAVIORAL HEALTH AND SOCIAL SERVICES (BEGINS WITH 10)	
101YA0400X	Addiction (Substance Use Disorder) Counselor
101YM0800X	Mental Health Counselor
103K00000X	Behavioral Analyst
103T00000X	Psychologist
1041C0700X	Clinical Social Worker
106H00000X	Marriage and Family Therapist

ADVANCED PRACTICE NURSING PROVIDERS	
Nurse Practitioner	
363LP0808X	Psychiatric/Mental Health
Clinical Nurse Specialist	
364SP0807X	Psychiatric/ Mental Health; child & adolescent
364SP0808X	Psychiatric/ Mental Health
364SP0809X	Psychiatric/ Mental Health; adult
364SP0810X	Psychiatric/ Mental Health; child & family
364SP0811X	Psychiatric/ Mental Health; chronically ill
364SP0812X	Psychiatric/ Mental Health; community
364SP0813X	Psychiatric/ Mental Health; geropsychiatric

ALLOPATHIC & OSTEOPATHIC PHYSICIANS	
Psychiatry & Neurology	
2084A0401X	Addiction Medicine
2084P0802X	Addiction Psychiatry
2084P0804X	Child & Adolescent Psychiatry
2084N0600X	Clinical Neurophysiology
2084D0003X	Diagnostic Neuroimaging
2084F0202X	Forensic Psychiatry
2084P0805X	Geriatric Psychiatry
2084P0005X	Neurodevelopmental Disabilities
2084N0400X	Neurology
2080P0006X	Developmental Behavioral Pediatrics
2084N0402X	Neurology with Special Qualifications in Child Neurology
2084N0008X	Neuromuscular Medicine
2084P0800X	Psychiatry
2084S0012X	Sleep Medicine
2084V0102X	Vascular Neurology
2084P0015X	Psychosomatic Medicine

Electronic Visit Verification (EVV)

Services subject to Electronic Visit Verification (EVV) will need to be submitted through HHAeXchange. Trillium has partnered with an external vendor, HHAeXchange, to provide the EVV tools necessary for designated providers to comply and meet this requirement. General EVV information can also be found on the HHAeXchange North Carolina Provider Information Center.

Pharmacy

Pharmacy claims are defined as those claims submitted for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims).

Pharmacy Point of Sale claims are processed through Trillium's partner, PerformRx and may be submitted electronically using the most current NCPDP HIPAA-approved format with **Rx BIN Number 019595** and **PCN—PRX10811**.

NEMT/NEAT

Modivcare is Trillium's contractor to facilitate Non Emergency Medical Transportation (NEMT) and Non Emergent Ambulance Transportation (NEAT) services in North Carolina. Modivcare responsibilities include booking of reservations/rides and to process claims for NEMT/NEAT providers.

Providers can bill electronically through Modivcare's web portal, by an Automated Transportation Management System (ATMS), or by submitting paper claims. For any questions on how to bill, Providers should refer to Modivcare's Orientation and Training resources. For claims related questions, please contact Modivcare's Claims Department at **1-800-930-9060**. For any other Provider related questions specific to Modivcare rides, please contact: **1-855-397-3604**. Additional NC resources may be found in Transportation Provider Manual.

Vision

Vision claims for Medicaid Tailored Plan beneficiaries are processed through Centene Vision (formerly Envolve), a subsidiary of CCH and may be submitted using HIPAA Standard Electronic Transaction set or can be submitted in a secure web-based Provider Portal. Claims may also be submitted through a clearinghouse. Centene Vision utilizes the clearinghouse Change Healthcare. As long as the provider's clearinghouse has a connection to Change Healthcare, then the claim can be passed on to Centene Vision. Centene Vision's Payer ID is **56190**.

Please refer to the Network Communication Bulletins and Urgent Notifications to providers for up-to-date information on system enhancements to Provider Direct. If you have any questions regarding Provider Direct, please email IT.Support@trilliumnc.org.

ii. Mandated Timelines

Timeframes for Submission of Claims

All claims must be submitted within the timeframes outlined in your provider contract from the date of service, or in the case of a health care provider facility, within 365 days after the date if the members' discharge for Medicaid funded claims. These timely requirements are in pursuant to N.C Gen. Stat 58-3-225(f).

Process for Submission of Replacement Paid Claims

Providers may submit replacement claims for originally paid claim. Services submitted outside of contracted timeframes may deny for exceeding billing days. Providers may complete a Claim Request Form (CRF), located on Trillium's website, for consideration of approval of claim denied for exceeding billing days.

Refer to Trillium's website for the purpose of the Claims Request Form (CRF) and CRF for completion.

Process for Submission of Voided Paid Claims

Providers may submit voided claims for originally paid claims. Voided claims will be reverted from our system and the original claim payment will be recouped.

R. INTEREST AND PENALTY PROVISIONS FOR LATE OR UNDER-PAYMENT BY THE BH I/DD TAILORED PLAN/PIHP

Any claim not paid within Timely Claim Payment limits will be subject to interest at the annual percentage rate of eighteen percent (18%). Interest is calculated for each calendar day after the date the clean claim should have been paid as specified in the contract between Trillium Health Resources and NC DHHS. In addition, Trillium Health Resources will pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the clean claim should have been paid as specified in the Contract between Trillium Health Resources and NC DHHS.

S. MEMBER RIGHTS AND RESPONSIBILITIES

The protection and promotion of member rights is a crucial component of the service delivery system. All members are assured rights by law. We expect all providers, to respect these rights at all times and provide members continual education regarding their rights, as well as support them in exercising their rights. N.C. General Statutes, Administrative code, and federal regulations outline rules and regulations about human rights.

Upon admission, Trillium notifies each member of the availability of the Trillium Member & Family Handbooks containing information to help them access services for severe mental health, intellectual/developmental disabilities and substance use. Electronic copies of the handbooks and other helpful documents are posted on our website.

The handbooks include information and instructions for members regarding:

- Where to call when they are in need of assistance
- A list of rights and responsibilities
- How to obtain services
- How to make a complaint or grievance
- Contact information for Trillium

The following is a list of Member rights:

- The right to request and receive information about Trillium, its services, its providers/practitioners, and member rights and responsibilities presented in a manner they can understand. Trillium notifies members of this right, annually.
- The right to be treated with respect and recognition of dignity and right to privacy.
- The right to participate with providers or practitioners in making decisions regarding health care and the right to refuse treatment.
- The right to a candid discussion with service providers/practitioners on appropriate or medically necessary treatment options regardless of cost or benefit coverage. Members may need to decide among relevant treatment options, the risks, benefits and consequences, including their right to refuse treatment and to express their preferences about future treatment decisions regardless of benefit coverage limitation.
- The right to voice complaints or grievances about the organization or the care it provides.
- The right to appeal decisions with which they disagree.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. If they present a danger to themselves or others, and there are no other means available to protect their safety and the safety of others, physical restraint may be used.
- The right to request and receive a copy of their medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. Therapeutic privilege means that if the doctor or therapist determines that this would be detrimental to their physical or mental well-being, they can request that the information be sent to a physician or professional of their choice.
- The right to write a statement to be placed in their file if they disagree with what is written in their medical records. However, the original notes will also stay in the record until the statute of limitations ends according to the State's retention schedule (11 years for adults; 12 years after a minor reaches the age of 18; 15 years for DWI records).
- The right for a treatment plan to be implemented within 30 days after services start. This is known as a Person-Centered Plan.
- The right to a second opinion from a qualified health care professional within or outside the Trillium network, at no cost to the member. Upon request,

- Trillium shall provide one second opinion from a qualified health care professional selected by Trillium, at no cost to the member. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. Trillium shall not be required to provide the member with a third or fourth opinion.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths and preferences.
- The right to take part in the development and periodic review of their treatment plan and to consent to treatment goals in it.
- The right to freedom of speech and freedom of religious expression, including the right to refuse treatment on moral or religious grounds.
- The right to equal employment and educational opportunities.
- The right to ask questions when they do not understand their care or what they are expected to do.
- The right to written notice of any "significant change" to the handbooks and/or contracts at least thirty (30) calendar days before the intended effective date of the change. A "significant change" is a change that requires modifications to the 1115 or 1915 (c) Waiver, a contract between Trillium and the State or Medicaid, or the Medicaid State Plan.
- The right to receive oral interpretation services free of charge. The right to request and receive a State Fair Hearing.
- The right to develop an Advance Directive for the mental health treatment they would like in the event of an emergency. They may contact Trillium Health Resources for assistance at1-877-685-2415. An Advanced Directive explains the treatment they would like and the people they would like to be involved. It also explains the things that they do not want. The right to file a grievance with the N.C. Division of Health Service Regulation or with Trillium if they feel the laws governing the advance directives have not been followed correctly.
- The right to be free of mental abuse, physical abuse, neglect and exploitation.
- The right to choose their Provider from the Trillium Provider Network. They have the right to change their choice of Provider at any time by calling the Member and Recipient Services 1-877-685-2415 or speaking to their care manager.
- The right to change their Tailored Plan PCP within 30 days from the date of receipt of their Medicaid ID card. After that they have the right to change their PCP one time each year without cause.

Members can change their PCP more than twice a year with good cause such as:

  - PCP does not provide accessible and proper care, services or supplies (for example, does not set up hospital care or consults with specialists when required for treatment).
  - PCP is not able to accommodate special needs.
  - Trouble communicating because of a language barrier or another issue.
  - They disagree with PCP's treatment plan.
  - PCP moves to a different location that is not convenient.
  - PCP changes the hours or days patients are seen.
  - Member and PCP agree that a new PCP is what is best for their care.
  - Person and PCP agree changing providers is in their best interest.
- Medicaid Direct beneficiaries have the right to choose their PCP and can change their PCP at any time and for any reason.
- Trillium shall hold the Member harmless for any costs associated with the transition between Providers, including copying medical records or treatment plans.

Trillium gives written notice of provider terminations to all Members who have been receiving services. Trillium shall notify each member, at a minimum, who received his or her primary care from, or was seen in the previous 12 months by a terminated provider.

Trillium shall give notice within fifteen (15) calendar days after Trillium receives notice that the Provider has terminated the Provider Agreement. When the Division of Health Benefits (DHB) or Trillium terminates a Provider Agreement with a network provider, Trillium shall give written notice of the termination to all Members who have been receiving services from the terminated Provider. Trillium shall give notice within fifteen (15) calendar days after Trillium receives notice that DHB has terminated the Provider Agreement or after Trillium provides notice of termination to the Provider (after the appeals deadline expires or all appeals have been exhausted).

- The right to treatment, regardless of age or disability. The treatment received will be age appropriate and in the least restrictive manner possible.
- The right to invite family or friends to help develop their Person-Centered Plan. The purpose of the Person-Centered Plan is to help them make goals to achieve their full potential.
- The right to be notified in advance of all potential risks and benefits of treatments.
- The right to be free from unnecessary or excessive medications. Medications will not be used as punishment or for the convenience of staff or family
- The right to refuse medications. This should always be discussed with their doctor.

- Members CANNOT be treated with Electroshock/ Electroconvulsive Therapy (ECT), experimental drugs or procedures, or be given surgery (unless it is an emergency surgery) without their written permission.
- The right to make recommendations regarding Trillium policies, procedures and services. If they would like to make recommendations regarding changes, they may contact Trillium Health Resources at 1-877-685-2415 or 201 West First Street Greenville, NC 27858-1132.
- The right to keep their care and medical records confidential. Even the fact that they are receiving services is confidential.
- Information about them can only be shared when:
  - They have given written consent.
  - There is a court order.
  - They become a danger to themselves or others and it is necessary for someone to submit involuntary commitment papers or find hospital placement for them.
  - They are likely to commit a serious crime. Their provider will share the information with the appropriate law enforcement agency.
  - Or as otherwise allowed by law.

Unless they have been declared incompetent by a court of law, and have a legal guardian appointed to them, they have the same basic rights as everyone else.

This includes a right to:

- Dispose of property
- Make purchases
- Enter into contractual relationships
- Vote
- Marry and divorce
- Develop a discharge plan prior to being discharged
- Receive a copy of their treatment plan
- Members are free to exercise these rights and exercising these rights shall not adversely affect the way the Tailored Plan or providers treat the member.

MEMBER RIGHTS AS A MINOR (UNDER THE AGE OF 18)

Minors have the right to:

- Proper adult supervision and guidance
- Age-appropriate activities, special education and vocational training if needed
- Appropriate structure and treatment separate from adults.

Minors can also agree to some treatments without the consent of a parent or guardian. These include:

- For treatment of sexually transmitted infection
- For pregnancy
- For abuse of controlled substances or alcohol

MEMBER RIGHTS IN A 24-HOUR FACILITY/ADULT CARE HOME

In addition to the above, members receiving care in a 24-hour facility or adult care home have the right to:

- Receive necessary medical care if they are sick. If their insurance does not cover the cost, then they will be responsible for payment.
- Receive a reasonable response to requests made to facility administrator or staff.
- Receive upon admission and during the stay a written statement of the services provided by the facility and the charges for these services.
- Be notified when the facility is issued a provisional (temporary) license or notice of revocation (reversal) of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. Their responsible family member or guardian shall also be notified.
- Send and receive unopened mail. Have access to writing material, postage, and staff assistance if requested.
- Contact and consult with a member advocate.
- Contact and see a lawyer, their own doctor, or other private professionals. This will be at their own expense, not at the expense of the facility.
- Contact and consult with their parent or legal guardian at any time, if they are under 18 years of age.
- Make and receive confidential telephone calls. All long-distance calls will be at their expense, not at the expense of the facility.
- Receive visitors between the hours of 8 a.m. and 9 p.m. Visiting hours must be available six hours each day. Two of those hours must be after 6 p.m. If they are under the age of 18, visitors cannot interfere with school or treatment.
- Communicate and meet with individuals that want to communicate and meet with them. This may be under supervision if their treatment team feels this is necessary.
- Make visits outside the facility, unless it has been included in the individual's Person-Centered Plan that this is not recommended.
- Be outside daily. Access to facilities and/or equipment for physical exercise several times per week.
- Have individual storage space for their private belongings that can be locked and only accessible by them, the administrator, or supervisor-in-charge.
- Keep personal possessions and clothing, except those items that are prohibited by law.
- Keep and spend a responsible sum of their own money; if the facility is holding money for them, they can examine the account at any time.
- Participate in religious worship if they choose.
- Retain a driver's license, unless they are not of age or have been prohibited to do so by a court of law.
- Not be transferred or discharged from a facility except for medical reasons, theirs or another's welfare, nonpayment, or if mandated by State or federal law. They must be given 30 days of notice except in cases of safety to themselves or others. They can appeal a transfer or discharge (according to rules by the Medical Care Commission), and they can stay in the facility until resolution of the appeal.

MEMBER/RECIPIENT RIGHTS FOR RESIDENTIAL PROVIDERS ONLY

Each individual shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care.

Such rights shall include, but need not be limited to the:

- Opportunity for a shower or tub bath daily, or more often as needed.
- Opportunity to shave at least daily.
- Opportunity to obtain the services of a barber or a beautician.
- Provision of linens and towels, toilet paper and soap for each person and other individual personal hygiene articles for each indigent person. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.
- Bathtubs or showers and toilets which ensure individual privacy shall be available.
- Adequate toilets, lavatory and bath facilities equipped for use by a person with a mobility impairment shall be available.
- An atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of people being served.
- Accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.
- Each shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

RIGHTS TO INFORMED CONSENT

Members have the right to be informed in advance of the potential risks and benefits of treatment options, including the right to refuse to take part in research studies.

Members have the right to consent to or refuse any treatment unless one of the following applies:

- It is an emergency situation
- They are not a voluntary patient
- Treatment is ordered by a court of law
- They are under 18 years of age, have not been emancipated and the guardian or conservator gives permission.

RIGHTS OF THOSE WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

If their primary disability is an intellectual/developmental disability, they have the right to continuity of care. If they are discharged from a residential facility and still need residential care, the provider MUST provide them with a sixty (60) day written notice as written into law General Statute 122C-63, "Assurance for Continuity of Care." This gives them time to find a new residence. This right exists as long as they have not committed any illegal acts or are not a safety threat to others.

RESTRICTED RIGHTS

Member rights can only be restricted for reasons related to their care or treatment by their treatment team. They must be part of their treatment team and the decision-making process. They have the right to have an advocate or someone they trust involved. A restriction of their rights must go through a Human Rights Committee for approval. Any restriction will be documented and kept in their medical record. Any implementation of restrictions requires a fading plan for the member to restore those rights.

VIOLATED RIGHTS

If member rights have been violated, contact the Member and Recipient Services at 1-877-685-2415. They can file a complaint or grievance in person or by phone. They do not have to give their name. If they feel their protected health information has been violated, they may file a complaint with Trillium by calling 1-877-685-2415. Trillium Health Resources complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Trillium Health Resources does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Trillium's non-discrimination rights can be found here.

Members who feel that their rights have been violated may also contact:

North Carolina Medicaid Contact Center
1-888-245-0179

Individuals living in Adult Care Homes have the right to report to the NC Division of Health Service Regulation (DHSR) any suspected violation of their member rights:

DHSR by mail

Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711

By Phone

Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500
Complaint Hotline Hours:
8:30 a.m.–4:00 p.m. weekdays, except holidays.

By Fax

Please fax information to 919-715-7724

ADVANCE DIRECTIVES

Members have the right to develop a plan for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. A plan may be referred to as an Advance Directive for Mental Health Treatment or a Psychiatric Advance Directive, which are interchangeable terms.

A statutory form for Advance Instruction for Mental Health Treatment is provided by N.C.G.S. §122C-77 of the North Carolina General Statutes. The member must sign the form in the presence of two (2) qualified witnesses and be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a resident, or a person related to the member or the member's spouse. The document becomes effective upon its proper execution and remains valid unless revoked.

Upon being presented with an Advance Directive, the physician or other provider must make it a part of the person's medical record.

The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the Advance Directive when the person is deemed to be incapable, unless compliance is not consistent with N.C.G.S. §122C-74(g), i.e., generally accepted practice standards of treatment to benefit the member, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a 24-hour facility and undergoing treatment as provided by law. If the doctor is unwilling to comply with part or all of the Advance Directive, he or she must notify the member and record the reason for noncompliance in the patient's medical record.

Under the Health Care Power of Attorney, a member may appoint a person as a health care agent to make treatment decisions on his/her behalf. The powers granted by this document are broad and sweeping and cannot be made by a doctor or a treatment

provider under NC law. Providers may decline to inform or counsel members of their right to develop an advance directive if the provider has a religious or moral objection to an item or service, such as an advance directive, that is furnished for the purpose of assisting in the causing of death. Providers may decline to apply or affect any requirement with respect to a portion of an advance directive that directs the purposeful killing, or the purposeful assisting in causing of, or the purposeful assisting in causing, the death of any individual if the provider has a religious or moral objection to applying or affecting such a requirement.

CONFIDENTIALITY

The network provider is required to ensure and maintain the confidentiality of all medical record information pertaining to all members and recipients served by them in the course of business. All confidential paper and medical record information must be safeguarded and secured according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all applicable federal and state confidentiality laws, rules, and regulations. This is to include 45 CFR Part 160 and 164-The Privacy Rule, and 42 CFR, Part 2-the confidentiality of substance abuse information in the medical record. Confidential information should not be discussed, transmitted or narrated in any form, except as authorized by the documented signature of a competent adult or and member's legally responsible person, or as other authorized by law. Secondary records which contain information about a specific member or members that can be personally identified shall be protected with the same safeguards and security as the original service record. Providers shall be monitored and reviewed to ensure that they demonstrate thorough and specific evidence of their compliance with HIPAA and other federal and state confidentiality laws in regard to the security and safeguarding with policy and procedure in regard to member's Protected Health Information (PHI).

Trillium will support providers by adhering to all confidentiality guidelines as stated in rule, regulation and law, and develop and disseminate educational material relative to accessing services, and member rights.

Information can be used without consent to help in treatment, for health care operations, for emergency care, and to law enforcement officers to comply with a court order or subpoena.

A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

A minor may authorize consent for release of confidential information under specific circumstances as outlined in APM45-1, Confidentiality Rules for Mental Health, Developmental Disabilities, and Substance Abuse Services.

This includes the following:

- Treatment of sexually transmitted infection
- Pregnancy
- Use of controlled substances or alcohol
- Emotional disturbance

If the member disagrees with what a physician, treating provider, clinician, or case manager has written in their records, the member can write a statement from their point of view to go in the record, but the original notes will also stay in the record in accordance with state requirements.

T. MEMBER COST SHARE REQUIREMENTS

Trillium imposes the same cost-sharing amounts as specified in North Carolina's Medicaid and state plans. Plan members are not required to pay for any covered services other than the co-payment amounts required under the state plans. Trillium tracks cost sharing obligations of each member.

Cost-sharing does not apply to the following:

Populations:

- Children under age twenty-one (21)
- Pregnant women
- Individuals receiving hospice care
- Federally-recognized American Indians/Alaska Natives
- Breast and Cervical Cancer Control Program (BCCCP) beneficiaries
- Foster children
- Disabled children under Family Opportunity Act
- 1915(c) waiver beneficiaries
- Traumatic Brain Injury (TBI) beneficiaries
- An individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

Providers:

- The billing provider is an IHP (Indian Health Provider)/Tribal Provider.
- The billing provider is a Federally Qualified Health Center.
- The billing provider is a Rural Health Center.
- The billing provider is NC Correction Enterprises (Nash Optical).
- A service is rendered at a tribal free-standing facility or tribal provider-based facility.
- The billing provider is providing a 1915(C) HCBS Service.
- The billing provider is a Comprehensive Outpatient Rehabilitation Facility.
- The billing provider is a Health Department billing for tuberculosis or a sexually transmitted disease or infection.

Services:

- Emergency services
- Postoperative, out of hospital care management associated with a surgical procedure.
- Family planning services
- HCPCS lines representing: Covid 19 Vaccine, Testing, Treatment
- A claim is billed with condition code AJ.
- Care/case management services
- Non-physician patient education
- Mental health crisis intervention
- Pathology or other lab testing procedures
- Radiology, echocardiography, or other imaging services
- Vaccine administration
- Claims billed with diagnosis codes associated with pregnancy, childbirth, and puerperium, to include prenatal care.
- Dialysis procedures or from a dialysis facility
- Medications billed as professional claims [PADP medications]
- DME, orthotics and prosthetics
- Home Infusion Therapy
- Annual adult wellness exam
- Pandemic-related services
- Claim is billed by a Health Department for tuberculosis or sexually transmitted disease or infection.
- HIV Antiretroviral (ARV) Medications
- Opioid Antagonist Medication
- Nicotine Replacement Therapy Medications
- Opioid Use Disorder Medications
- Approved Adult Vaccines and Administration Recommended by the Advisory Committee on Immunization Practices (ACIP).

U. PROVIDER PROGRAM INTEGRITY REQUIREMENTS

i. How to Report Suspected Fraud, Waste, and Abuse

Fraud, Waste, and Abuse Reporting

All providers must monitor for possible fraud, waste and abuse and take immediate action to address reports or suspicion. Trillium has initiated EthicsPoint, a secure and confidential tool to report suspected violations of fraud, waste, abuse, ethics and compliance issues. Reports can be made online or by calling the toll-free telephone tip line (1-855-659-7660). EthicsPoint is available 24 hours a day, 7 days a week and 365 days a year. The hotline is confidential and Trillium will honor this anonymity in full compliance with the standards.

Providers may report fraud, waste, and abuse concerns by utilizing one of the following mechanisms:

- Trillium toll-free, anonymous, EthicsPoint Hotline
- Anonymous online submission through the EthicsPoint web address listed above
- NC DHB Fraud, Waste, and Abuse Report line at 1-877-362-8471
- NC DHB Online Confidential Complaint Form on the DHB website (For a link to this form and additional information of Medicaid Fraud, Waste, and Abuse, please see Resources & Web Links section at the end of the Manual)

To make a report:

- EthicsPoint
- Call toll free: 1-855-659-7660

ii. Waste and Abuse

PROGRAM INTEGRITY

Trillium Health Resources operates a Special Investigations Unit (SIU) within the Compliance Department with dedicated staff residing in North Carolina. This unit routinely inspects claims submitted to assure Trillium is paying appropriately for covered services. The Special Investigations Unit within the Compliance department is charged with preventing, detecting and correcting fraud, waste,and abuse to ensure the financial and clinical integrity of Trillium's contracted providers are maintained. The team conducts post-payment audits, monitoring and investigations to assure payments made to providers for services are rendered in accordance with rules, regulations, policies, and the terms of the provider contract. The team receives allegations of fraud, waste and abuse from various sources to include: a tip-line, complaints, incident reports, issues identified by staff, data mining, detection tools, and statistical sampling. The team conducts reviews of all allegations and if warranted conducts an investigation.

The team makes referrals of suspected fraud to Division of Health Benefits (DHB)—Office of Compliance and Program Integrity and other appropriate regulatory bodies.

iii. Compliance with Other State and Federal Requirements

Trillium Health Resources instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Per contractual requirements, contracted providers of Trillium are required to cooperate fully with all investigative requests, including but not limited to immediate access to any of the contractual locations/ sites, where services are provided to members and recipients, in addition to any site where financial or clinical records are maintained. Providers are required to cooperate with request to view or submit members' and recipients medical records for review. Medical records should be maintained in compliance with all state and federal laws related to record retention, more information on this can be found in the Compliance section related to Member/Recipients Records Requirements. Failure to do so may be grounds for contract termination.

FRAUD, WASTE, AND ABUSE INVESTIGATION

Any credible allegation of potential fraud, waste and abuse involving Trillium providers will be referred to Trillium's Special Investigations Unit of the Compliance Program Integrity Department for investigation and action. Investigations may be conducted on-site or by desk review. Findings will be reported to DHB-Office of Compliance and Program Integrity ("DHB-OCPI") North Carolina Medicaid Investigation Division ("MID")"appropriate regulatory bodies, and/or law enforcement agencies depending on the nature of the allegation. Any allegations of provider fraud that are accepted by DHB—OCPI may result in immediate suspension of referral, authorizations and payments pending an investigation by DHB or the MID.

FRAUD, WASTE, AND ABUSE MONITORING AND AUDITING

Trillium has adopted a fully operational set of processes that proactively protects the agency and detects fraud and abuse, which contains both internal and external components. Trillium has taken reasonable steps to monitor, audit, and document questionable business practices, also known as fraud, waste, and abuse.

- **Abuse** is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.
- **Fraud** is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person.
- **Waste** is defined as costs that could have been avoided without a negative impact on quality.

Examples of Medicaid fraud, waste, and abuse include, but are not limited to:

- A member does not report all income when applying for Medicaid.
- A member does not report other insurance when applying for Medicaid.
- A non-member uses a member's card with or without the recipient's knowledge.
- A provider's credentials are not accurate.
- A provider bills for services which were not rendered.
- A provider performs and bills for services not medically necessary

Prepayment Review

Trillium's Prepayment Claims Review program seeks to ensure claims presented by providers for payment meet federal and state laws and regulations and medical necessity criteria in advance of payment. Trillium bases prepayment review process on guidance from NCGS 108 C-7. Trillium may require a provider to undergo Prepayment Claims Review if Trillium receives allegations of suspected provider fraud, waste, and abuse, identification of aberrant billing practices as result of an investigation or data analysis, or other grounds as defined by Trillium. Trillium notifies the provider in writing of the decision and the process for submitting prepayment claims no less than 20 calendar days prior to instituting Prepayment Claims Review. A provider may not appeal or otherwise contest a

decision of Trillium to place or maintain a provider on Prepayment Claims Review. The provider will not be entitled to payment prior to claims review by Trillium.

The Prepayment Claims Review Initial Notice letter provides the following:

1. An explanation of Trillium's decision to place the provider on Prepayment Claims Review.
2. A description of the review process and claims processing times.
3. A description of the claims subject to Prepayment Claims Review.
4. A specific list of all supporting documentation the provider will need to submit with the claims subject to the Prepayment Claims Review.
5. The process for submitting claims and supporting documentation.
6. The standard of evaluation used by Trillium to determine when a provider's claims will no longer be subject to Prepayment Claims Review.

For any claims in which Trillium has given prior authorization, Prepayment Claims Review will not include review of the medical necessity for the approved services. Trillium processes all clean claims submitted for Prepayment Claims Review within 20 calendar days of submission by the provider. If the provider fails to provide any of the specifically requested supporting documentation necessary to process a claim, Trillium sends to the provider written notification of the lacking or deficient documentation within 15 calendar days of receipt of such claim. Trillium has an additional 20 calendar days to process a claim upon receipt of the documentation. The provider has 5 business days to submit the records. If the provider does not submit requested documentation within five business days, the claims will be denied for payment as "No Documentation Submitted." Approved claims are manually entered and adjudicated based on the edits set up within the system. Payment will then follow normal check write process.

The provider remains subject to the Prepayment Claims Review process until the provider achieves 3 consecutive months of 70% accuracy provided the number of claims submitted per month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted. If the provider does not meet this standard within 6 months of being placed on Prepayment Claims Review, Trillium may impose further sanctions. In no instance will the Prepayment Claims Review continue longer than 24 consecutive months unless Trillium has initiated sanctions on the provider and the provider has appealed sanctions. If Trillium has initiated sanctions on the provider and the provider has appealed the sanctions, then the provider shall remain on prepayment review until the final disposition of Trillium's sanction of the provider.

If a provider contract is terminated while on Prepayment Claims Review, the provider number is not removed from Prepayment Claims Review if the provider has not met established accuracy goals. Trillium continues to receive reports through the completion of the 6month review period and compiles a case summary including the provider number end-date and reason. Should the business owner(s) of the end-dated provider open a new business under a new name and Medicaid number, the prepayment review process will be implemented on that new provider number.

Failure of a provider to meet the seventy percent (70%) clean claims rate minimum requirement may result in a termination action. A termination action taken shall reflect the failure of the provider to meet the seventy percent (70%) clean claims rate minimum requirement and shall result in exclusion of the provider from future participation in the Medicaid program. If a provider fails to meet the seventy percent (70%) clean claims rate minimum requirement and subsequently requests a voluntary termination, the termination will reflect the provider's failure to successfully complete prepayment claims review and will result in exclusion of the provider from future participation in the Medicaid program.

Providers should not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the provider has been taken off of prepayment review for any reason, including attaining a minimum of seventy percent (70%) clean claims rate for 3 consecutive months, the expiration of the 24-month time limit, or the termination of the provider.

The decision to place or maintain a provider on prepayment claims review does not constitute a contested case under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of Trillium to place or maintain a provider on prepayment review.

If a provider elects to appeal Trillium's decision to impose sanctions on the provider as a result of the prepayment review process to the Office of Administrative Hearings, then the provider has 45 days from the date the appeal is filed to submit any documentation or records addressing or challenging the findings of the prepayment review. Trillium will not review, and the administrative law judge shall not admit into evidence, any documentation or records submitted by the provider after the 45-day deadline. In order for a provider to meet its burden of proof under G.S. 108C-12(d) that a prior claim denial should be overturned, the provider must prove all required documentation was provided at the time the claim was submitted and was available for review by the prepayment review vendor and the claim should not have been denied at the time of the vendor's initial review.

When a provider meets the 70% claims accuracy rate, Trillium notifies the provider in writing they have successfully completed the Prepayment Claims Review process. Additional information related to Prepayment Claims Review details for providers can be located in the Provider Manual

FALSE CLAIMS ACT

The False Claims Act was a law that was established to punish persons or entities that file false or fraudulent claims for payments by government agencies.

The False Claims Act makes it unlawful for any Medicaid provider to knowingly make or cause to be made, a false claim for payment, "Knowingly" is defined as:

- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsifies the information.

The penalty can range from $11,000–$22,000 for each false claim submitted. The provider may be required to pay back up to three times the amount of damages sustained by the government.

If convicted, the provider may be excluded from participation in federal health care programs. In addition, most private insurance programs will also exclude the provider from participation as well.

V. SECTIONS MEDICAID PROVIDERS

i. Clinical Practice Standards

Clinical Practice Guidelines can be found on our website.

NCDHHS Community-Based Services Clinical Coverage Policies (CCPs)

NCDHHS offers Community Based Services for members meeting the requirements outlined in NCDHHS' Community Based Services Clinical Coverage Policies (CCPs).

Community Based Services include the following:

- Program for All-Inclusive Care for the Elderly (PACE)
- Hospice Services
- Private Duty Nursing for beneficiaries age 21 and Older
- Private Duty Nursing for beneficiaries under age 21
- Home Infusion Therapy
- Community Alternatives Program for Disabled Adults (CAP/DA-Choice)
- State Plan Personal Care Services (PCS)

Review the Clinical Coverage Policies (CCPs) in detail at NCDHHS Community Based Services CCP. Should you have questions regarding these policies, you may contact Trillium's Provider Support Line to obtain additional information.

NCDHHS Physician Clinical Coverage Policies (CCPs) for Visual and Auditory Services

The NCDHHS offers Visual and Auditory Services and supports for members meeting the requirements outlined in NCDHHS' Physician Clinical Coverage Policies (CCPs).

Visual and Auditory Services include the following:

- Cochlear and Auditory Brainstem Implants
- Blepharoplasty/Blepharoptosis (Eyelid Repair)
- Ocular Photodynamic Therapy
- Transcranial Doppler Studies
- Visual Evoked Potential (VEP)
- Tympanometry and Acoustic Reflex Testing
- Implantable Bone Conduction Hearing Aids (BAHA)

Review the CCPs policies for visual and auditory coverage in detail at NCDHHS Physician Clinical Coverage Policies. Should you have questions regarding these policies, you may contact Trillium's Provider Support Line to obtain additional information.

Long-Term Hospital Services Clinical Coverage Policy (CCP)

Review the Long-Term Care Hospital Services for members meeting the requirements, outlined in detail at NCDHHS' Long Term Care Hospital Services CCP. Should you have questions regarding this policy, you may contact Trillium's Provider Support Line to obtain additional information.

Child Medical Evaluation and Medical Team Conference for Child Maltreatment 1A-5 CCP

The NCDHHS' Child Medical Evaluation and Medical Team Conference for Child Maltreatment Clinical Coverage Policy (CCP) details the requirements for Medical Evaluations and Medical Team Conferences. Review NCDHHS' Child Medical Evaluation and Medical Team for CCM, 1A-5. Should you have questions regarding this policy, you may contact Trillium's Provider Support Line to obtain additional information.

ii. Authorization, Utilization Review, and Care Management Requirements

Care Management

The primary Utilization Management function is to make authorization decisions by conducting initial, concurrent and retrospective reviews of services based on meeting medical necessity. UM will determine whether a member/recipient meets medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services. UM Care managers assist the provider in managing a member's/recipient's care needs and identification of appropriate services.

Treatment Authorization Request Forms

Trillium uses a Treatment Authorization Request (TAR) form to capture demographic and clinical information.

The TAR assists the UM Care manager in making the clinical determination. The TAR must include accurate and complete clinical information to avoid a delay or denial of authorization request.

An instruction manual is available for review by logging into Provider Direct and selecting the Training Materials link from the Client Gateway. Any provider can request technical assistance on TAR submission by contacting Trillium at PDSupprt@Trilliumnc.org.

The purpose of this process is to identify the steps required in requesting prior-authorization and continued authorization from the Utilization Management unit. Requesting the Authorization is the responsibility of the provider.

Electronic notification of UM decisions may be found in the web portal so it is the responsibility of the provider to check the portal regularly.

For a full listing of all North Carolina Medicaid State Plan Service Definitions and Criteria, visit the Division of Health Benefits (DHB) website. (See the Resources & Web Links section at the end of this Manual for the link to this website.)

Utilization Review

The primary Utilization Review function is to monitor the utilization of mental health, substance use and intellectual/ developmental disability services and review utilization data to evaluate and ensure that services are being provided appropriately within established benchmarks and clinical guidelines; that services are consistent with the authorization and approved Person-Centered Plan (PCP)/Individual Support Plan (ISP)/Treatment Plan.

iii. Notification of the availability of the Department's provider Ombudsman service

North Carolina Medicaid offers a Provider Ombudsman to assist providers transitioning to Medicaid Managed Care by receiving and responding to inquiries, concerns and complaints regarding health plans. This service is intended to represent the interests of the provider community, provide supportive resources and assist with issues through resolution.

The Ombudsman will also investigate and address complaints of alleged maladministration or violations of rights against the health plans. Health plans are expected to resolve complaints promptly and furnish a summary of final resolution to North Carolina Medicaid. Inquiries may be submitted to Medicaid. ProviderOmbudsman@dhhs.nc.gov or the Medicaid Managed Care Provider Ombudsman at **1-866-304-7062**.

iv. Disaster and Emergency Relief Planning and Response

Provider Care to Members

Trillium's contracted providers and delegated vendors are required to have disaster plans that include evacuation, fire, and emergency response. Trillium and providers will plan and respond in the event of a disaster or emergency that results in a major failure or disruption in care, including but not limited to fire, flood, hurricanes/tornados, terrorist events, earthquake, and/or an epidemic or pandemic disease. Trillium and delegated vendors communicate with the provider network, to the extent possible, during a crisis such as a natural or human caused emergency or disaster as to their status and ability to provide services. Trillium contacts Residential, Opioid Provider Treatment, and Medication Assistance Treatment providers to ensure emergency plans are being followed prior to any emergency event. Trillium completes outreach efforts to Members to review their emergency plan. Trillium offers our network of providers various resources and educational material that assist our Members and Recipients during disaster events.

Our resources and education material can be found on our website TrilliumHealthResources.org and Provider My Learning Campus. My Learning Campus is free online training and contains tip sheets for providers to access. Such resources include but are not limited to accessibility to TAP 43 Disaster Plan Handbook for BH Service Programs and Ready.gov Tool kit. Trillium's trainings on My Learning Campus provide an introduction on our Regional Behavioral Health Crisis and Disaster Unit, its purpose, and how they can help during a disaster. Trillium offers a series of trainings for providers that provide support for members: Disaster Response Training for NC MH Providers, CMH-Community Crisis and Disaster Response, Care Management Community Crisis and Disaster Response Training. Trillium's approach is to make these resources accessible so providers can be properly trained and ready prior to an event occurring.

Provider Support

Prior to a potential disaster event, Trillium utilizes several different avenues to reach our providers such as but not limited to: Network Communications, Urgent Notifications, social media. These communication efforts provide direction to the provider on how to contact Trillium if they were to be impacted. Trillium created a webpage devoted to Community Crisis and Disaster Response which provides updated information. Trillium has staff devoted to monitoring the Change in Provider Operations Tracking tool which requires prompt action by the staff to ensure the provider's questions are answered promptly. Afterhours Trillium's Community Disaster Response Unit is available to answer provider questions and escalate provider concerns as needed. This team is on call afterhours and follows an escalation process to Regional Directors if additional support is needed. Additionally, they will provide information to the Network team for any information provided or any follow-up needed. Trillium has Provider Support Service Line that currently operates Monday through Saturday, 7 a.m.– 6 p.m. and staffs six full-time support specialists and one full-time manager. Employees reside in North Carolina and work within and throughout Trillium's catchment area. During disaster events, Trillium establishes a team of staff in which job is to answer provider's questions and provide resources.

W. PROVIDER OBLIGATIONS

i. Monitor and audit Provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse

Fraud, Waste, and Abuse Reporting

All providers must monitor for possible fraud, waste, and abuse and take immediate action to address reports or suspicion. Trillium has initiated EthicsPoint, a secure and confidential tool to report suspected violations of fraud, abuse, ethics and compliance issues. Reports can be made online or by calling the toll free telephone tip line 1-855-659-7660. EthicsPoint is available 24 hours a day, 7 days a week and 365 days a year. The hotline is confidential and Trillium will honor this anonymity in full compliance with the standards.

ii. Monitor and report on provider preventable conditions

Trillium will comply with contractual policies/ requirements as set forth by the North Carolina Department of Health and Human Services in regards to the reimbursement of provider preventable conditions. Not required for State-funded providers.

There are two categories of PPCs:

1. **Health Care-Acquired Conditions (HCAC)**— This term applies to Medicaid inpatient hospital settings and includes at a minimum the full list of Medicare's hospital acquired conditions (except Deep Vein Thrombosis/Pulmonary Embolism following total knee/hip replacement in pediatric and obstetric patients).
2. **Other Provider**— Preventable Conditions (OPPC)This term applies to Medicaid inpatient and outpatient health care settings where these events may occur and includes at a minimum the subjects of three Medicare National Coverage Determinations (surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery).

iii. Retain Patient Records for the mandated period

Providers adhere to the regulations set forth for record retention as addressed in the following: DHHS Records Retention and Disposition Schedule for Grants; the Records Retention and Disposition Schedule for State; APSM 10-3 Records Retention and Disposition Schedule; and APSM 10-5, Records Retention and Disposition Schedule.

iv. Ensure that all documentation regarding services provided is timely, accurate, and complete

Trillium will ensure all documentation regarding services provided is timely, accurate, and complete.

v. Ensure BH I/DD Tailored Plan/PIHP is the payer of last resort

The BH I/DD Tailored Plan should be payer of last resort. All other funding options need to be exhausted first. Recipients with private or group insurance coverage are required to pay the co-pay assigned by their insurance carrier.

vi. To report and promptly return overpayments within 60 Calendar days of identifying the overpayment

Trillium will report and promptly return overpayments within sixty (60) days of identifying the overpayment.

X. LIST OF REVISIONS

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Added Known System Issues Tracker Link	69 Resources & Weblinks	J b	05/19/23
Removed DHHS reference as a member is not required to send the appeal form to DHHS.	116	Z	05/19/23
Removed statement that a member is not required to file State Fair Hearing with Trillium.	117	Z	05/19/23
Added that members can also file request for State Fair Hearing orally and listed the phone number.	117	Z	05/19/23
Added a redlined Provider Manual will be available.	NA	c	05/19/23
Updated the link for the State Benefit Plan criteria outlined by DHHS to FY23	28	D	5/19/23
Revised appeal timeframe	74	N	5/19/23
Revised member and provider satisfaction survey	79	P	5/19/23
Deleted ECHO	79	P	5/19/23
Revised and added Core details	80	P	5/19/23
Added incident exception	83	P	5/19/23
Revised to Quality Management and Improvement Program	84 131	P FF	5/19/23
Replaced Quality Improvement Activities to Performance Improvement Project	95 134	S EE	5/19/23
Added data and methods	133	EE	5/19/23
Revised State-Funded Time and Distance Table	46–48	I	7/7/23

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Revised Disenrollment information	111	Z	7/7/23
Revised the frequency of changing a PCP	93	S	7/7/23
Deleted requirement to notify Trillium any change in status	33	F	7/7/23
Edited claims submission	33 90	F Q	7/7/23
Deleted monthly exclusion list monitoring	38–39	G	7/7/23
Deleted termination of credentials	42	G	7/7/23
Revised requirement to notify Trillium of changes	42	G	7/7/23
Deleted requirement to notify Trillium of changes	c	c	7/7/23
Deleted Assertive Engagement and deleted Case Management in table	43–44	G	8/1/23
Removed requirement to complete New Provider Orientation Training for rates to be initialized in the contract	33	F	10/13/23
Added the requirement to complete Provider Direct System Administrator training before receiving access to Provider Direct	34	F	10/13/23
We ended the Seal Program this Jan.	135	FF	1/23/24
Updated the list to 46 counties	113	Z	1/23/24
Updated claims submission protocol table	58	J	2/1/24
Updated claims submission protocol	58	J	5/28/24
Revised to state the Provider Manual is available on Trillium's website	ii	A	7/1/24
Updated NCQA Designation	ii	A	7/1/24

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Added UM Program Policies Link	2	B	7/1/24
Added details for Children and Youth Services	31	E	7/1/24
Revised primary role of the Clinical Support Unit	31	E	7/1/24
Revised days allowed for claims submission	33	F	7/1/24
Updated Time/Distance Standards for Medicaid	45	I	7/1/24
Added Exceptions for TPL	58	J	7/1/24
Revised Claims Submission Protocol	58	J	7/1/24
Revised Provider Appeals Process	74	N	7/1/24
Revised definition of complaint, resolution letter and timeframes	74	N	7/1/24
Revised Performance Improvement	80	P	7/1/24
Revised NC-TOPPS Hierarchy	80	P	7/1/24
Revised NC-SNAP	80	P	7/1/24
Revised Claims Submission Protocol	78	O	7/1/24
Updated Member Cost Sharing Requirements	100	T	7/1/24
Added details to Prepayment Review Process	101	U	7/1/24
Deleted Provider Council Objective related to the Local Business Plan	130	DD	7/1/24
Deleted and added Committee	135	FF	7/1/24
Revised Board and CFAC Structure	142	HH	7/1/24
Revised Executive Team Functional Areas	143	HH	7/1/24
Revised Claims Submission Protocol	63	J	10/8/24
Revised Claims Submission Protocol	89	Q	10/8/24

Y. MEDICAL AFFAIRS

i. Opioid Misuse Prevention and Treatment Program

Trillium recognizes the seriousness of the ongoing opioid epidemic and is dedicated to helping improve the lives of our members with opioid dependency and substance use disorder across the prevention to treatment continuum throughout our identified populations and catchment areas. Trillium is committed to increasing prevention awareness, harm reduction strategies, and connecting our members to the appropriate treatment programs for opioid addiction as well as improving access to overdose reversal drugs. We are also dedicated to the expansion of prevention, treatment, and recovery support services within our catchment areas.

We abide by the recommendations set by the North Carolina Opioid Action Plan, including the following:

Prevention:

- Cutting the supply of available opioids (both prescribed and illegal)
- Promoting safe prescribing practices
- Lock In Program-helps identify members that are at risk for possible overuse or improper use of pain medications
- Educating youth about the harms of using opioids
- Regular Screening to identify youth at risk
- Working collaboratively with schools and local youth organizations to provide education and resources
- Providing education and support to parents
- Improving treatments for expectant mothers currently using opioids
- Specialized Screening
- Referrals to substance use programs focused on expectant mothers and/or mothers of young children

Reducing Harm:

- Education to members, families, providers and the community about opioid dependence, opioid Overdose and how to get help, Narcan/ Naloxone kits, the purpose of the kit, and where the kits are available.

Connecting to Care:

- Expanding the number of providers offering treatment and recovery services
- Expanding the use of telehealth
- Addressing the needs of justice-involved populations
- Integrated projects with community partners through local community collaborative meetings

ii. Tobacco Cessation Plan

Trillium contracts with Quit Now to promote treatments to help a person quit smoking and using other nicotine products. We work with providers to offer tobacco-free sites and facilities, encourage the use of nicotine replacement and other medications, and educate the public about the effects of continued tobacco use.

If a person is a current smoker and would like to stop, please reach out to one of the contacts below:

Quit Now
1-800-QUIT-NOW

Trillium Member & Recipient Services
1-877-685-2415

Z. TRILLIUM BENEFIT PLAN

i. Tailored Plan Eligibility

The Behaviorial Health I/DD Health Plan (1115 waiver)

North Carolina Medicaid members, whose county of eligibility falls within those listed, that require certain services to address needs for an intellectual/developmental disability (I/DD), traumatic brain injury, serious mental illness, serious emotional disturbance, or severe substance use disorder may be eligible to enroll in Trillium's Behavioral Health I/DD Tailored Plan (NCGS 108D-40(a)(12).

The member's Medicaid County of Eligibility is:

Anson	Guilford	Pasquotank
Beaufort	Halifax	Pender
Bertie	Hertford	Perquimans
Bladen	Hoke	Pitt
Brunswick	Hyde	Randolph
Camden	Jones	Richmond
Carteret	Lee	Robeson
Chowan	Lenoir	Sampson
Columbus	Martin	Scotland
Craven	Montgomery	Tyrrell
Currituck	Moore	Warren
Dare	Nash	Washington
Duplin	New Hanover	Wayne
Edgecombe	Northampton	Wilson
Gates	Onslow	
Greene	Pamlico	

The NC Innovations Waiver (1915(c) waiver)

A person with an intellectual disability and/or a related developmental disability may be considered for NC Innovations Waiver funding based on an allotment from the North Carolina General Assembly, and not determined by Trillium, if all of the following criteria are met:

- They are a U.S. citizen or provide proof of eligible immigration status.
- They are a resident of North Carolina.
- They are have a Social Security number or have applied for one.
- They have applied and have been approved for Medicaid at the local Department of Social Services (DSS) Office
- They are in one of the Medicaid categories that qualifies members for the Behavioral Health I/DD Health Plan.

The member's Medicaid County of Eligibility is:

Anson	Guilford	Pasquotank
Beaufort	Halifax	Pender
Bertie	Hertford	Perquimans
Bladen	Hoke	Pitt
Brunswick	Hyde	Randolph
Camden	Jones	Richmond
Carteret	Lee	Robeson
Chowan	Lenoir	Sampson
Columbus	Martin	Scotland
Craven	Montgomery	Tyrrell
Currituck	Moore	Warren
Dare	Nash	Washington
Duplin	New Hanover	Wayne
Edgecombe	Northampton	Wilson
Gates	Onslow	
Greene	Pamlico	

- The member is eligible for Medicaid coverage, The member is eligible for Medicaid coverage, based on assets and income of the applicant whether he/she is a child or an adult.
- The member meets the requirements for ICF-IDD level of care. Refer to the Trillium NC Innovations Operations Manual for the ICF-IDD Criteria.
- Lives in an ICF-IDD facility or is at high risk for placement in an ICF-IDD facility.
- High risk for ICF-IDD institutional placement is defined as a reasonable indication that member may need such services in the near future
- The member's health, safety, and well-being can be maintained in the community with waiver support.
- The member, his/her family, or guardian desires participation in the NC Innovations Waiver program rather than institutional services.
- The member will use one waiver service per month for eligibility to be maintained.
- NC Innovations Waiver members must live in a private home (either independently or with family/roommate) or in living arrangements with six (6) or fewer persons unrelated to the owner of the facility.
- Qualifies for the NC Innovations Waiver and has been assigned a waiver "slot."

Trillium maintains a Registry of Unmet Needs for members who would like to be reviewed for eligibility for the Innovations Waiver. To be placed on the Registry of Unmet Need,s please contact the Member and Recipient Services at 1-877-685-2415, or by email RUN@TrilliumNC.org.

Please refer to the applicable Benefit Plan on the Trillium website.

ii. Enrollment

Providers must ensure member enrollment data is up to date based on the most current Trillium enrollment procedures and training. If enrollment data is not complete prior to service provision, authorizations and claims may be affected. This could result in denial of authorizations requested and/or claims submitted for reimbursement.

Service Eligibility

Services are divided into multiple service categories as follows:

Basic Services

The Basic Benefit package includes those services that will be made available to Medicaid-entitled members and, to the extent resources are available to non-Medicaid members. These services are intended to provide brief interventions for members with acute needs. The Basic Benefit package is accessed through a simple referral from Trillium to an enrolled Trillium provider. Once the referral is made, there are certain specified unmanaged visits for adults and children that require no prior authorization for these services.

Enhanced Services

The Enhanced Benefit package includes those services available to Medicaid-entitled members and to non-Medicaid members meeting State Benefit Plan criteria.

Enhanced Benefit services are accessed through a person-centered planning process and provide a range of services and supports more appropriate for members requiring higher levels of care. The person-centered plan also includes both a proactive and reactive crisis contingency plan. The goal is to ensure these members' services are highly coordinated, reflect best practice, and are connected to the person-centered plan authorized by Trillium.

State Benefit Plans

State Benefit Plan designation is for State-funded services. It does not apply to members who are only receiving Medicaid services. The provider, through review of screening, triage and referral information, must determine the specific State Benefit Plan for the member according to the Division of MH/DD/SA Criteria.

Each State Benefit Plan is based on diagnostic and other indicators of the member's level of need. The most current version of State Benefit Plan Criteria can be found on the NC Division of MHDDSAS website(See the Resources & Web Links section at the end of this Manual for the link to this information.)

iii. Disenrollment

Tailored Plan and Medicaid Direct Members are disenrolled based upon eligibility decisions made by the Department of Health Benefits (DHB) and as received on the eligibility file provided by DHB. If a member is disenrolled due to loss of eligibility as indicated on the eligibility file provided by DHB, the member will be automatically reenrolled at the point in which the eligibility is reflected as active on a subsequent eligibility file.

State-funded recipients are disenrolled if they become eligible for North Carolina Medicaid and are members of a Standard Plan.

Incentives

Trillium does not offer incentives that would discourage requests or approval of service requests. Decision making is based solely on appropriateness of care and existence of coverage. We do not offer incentives for Utilization Management staff or contractors to deny, reduce, terminate, suspend, limit or discontinue medically necessary services to any member. We also do not offer physician incentive plans.

Focused Utilization Review

A Focused Review will be based on the results of Monitoring Reports that identify outliers as compared to expected/established service levels or through specific cases identified in the Trillium clinical staffing process to be outside the norm.

Focused samples may include:

High-risk members—Examples may include, but are not limited to, members who have been hospitalized more than one time in a 30-day period; members with intellectual/developmental disabilities as identified in the Risk/Support Needs Assessment; children and youth with multiple agency involvement; or active substance use by a pregnant female.

Under-utilization of services—Examples may include, but are not limited to members who utilize less than 70% of an authorized service or members who have multiple failed appointments.

Over-utilization of services—Example: members who continue to access crisis services with no engagement in other services.

Services infrequently utilized—Example: an available practice not being used.

High-Cost Treatment—Members in the top 10% of claims for a particular service.

Routine Utilization Review

Routine Utilization Review (UR) will focus on the efficacy of the clinical processes in cases as they relate to reaching the goals in the member's/recipient's PCP/ISP/treatment plan.

Trillium will also review the appropriateness and accuracy of the service provision in relation to the authorizations. All providers contracted with Trillium who are currently serving Trillium members/recipients are subject to URs to ensure that clinical standards of care and medical necessity are being met. A routine UR will be inclusive of, but not limited to: evaluations of services across the delivery spectrum; evaluations of members by diagnostic category or complexity level; evaluations of providers by capacity, service delivery, and best-practice guidelines and evaluations of utilization trends.

The criteria used in the Utilization Review processes will be based on the most current approved guidelines and service manuals utilized under the 1115 and 1915(c) waivers and processes for NC State services.

These documents include, but are not limited to, the current NC State Plan service definitions with Admission, Continuation, and Discharge criteria; the Trillium approved Clinical Guidelines; the current approved DHB policies; and any Trillium-approved clinical guidelines developed and/or recommended by the Clinical Advisory Committee.

In cases where the care that is needed is emergent or acute, an expedited request for authorization, if necessary, is available up to 48 hours after admission. Medical necessity criteria must be established by the provider along with other clinical information. Trillium has created an environment that supports rapid access for many crisis services to divert from unnecessary inpatient hospitalization.

Authorization Process

1. Prior-authorization is required for all Trillium covered services, with the following exceptions:

- Basic Services, within prescribed levels, see current benefit plan for details
- Emergency/Crisis services for Behavioral Healthcare
- Emergency Services, Family Planning, Children's Screening Services
- Codes specifically agreed upon by Trillium and provider to be listed as "No Auth Required" under a contract; (see your contract for applicability)
- Services that have a "pass through" as outlined in Clinical Coverage Policy, see current benefit plan for details

2. To remain consistent with Division of Health Benefits (DHB) guidelines, the Trillium Utilization Management (UM) Department is only able to make formal decisions (approval, denial or extensions when appropriate) when a complete request is received.

For a request to be considered "complete" it must contain the following elements.

- Member Name
- Medicaid ID
- Date of Birth
- Provider contact information and signatures
- Date of request
- Service(s) requested
- Service Order
- Completed Check boxes (Signature Page / Service Order Yes or No Check Boxes related to medical necessity, direct contact with the member, and review of the member's Clinical Assessment)
- Person-Centered Plan (PCP)/Individual Support Plan (ISP) (if applicable)
- A copy of the Comprehensive Clinical Assessment (CCA), Psychoeducational Testing, or other assessments or documentation to support medical necessity.

Level of care tool scores will also help determine medical necessity and these may include LOCUS©, CALOCUS©, ASAM, and The Early Childhood Services Intensity Instrument (ECSII) for Infants, Toddlers and Pre-Schoolers.

A Person-Centered Plan/Individual Support Plan/ treatment plan by itself does not initiate a request for service.

If Trillium receives a TAR requesting a service or frequency different from the PCP/ISP/treatment plan, it can be administratively denied due to lack of information.

If Trillium receives a TAR without the required corresponding PCP/ISP/treatment plan, it will be administratively denied due to lack of information and provider notified via TAR comments in Provider Direct.

Electronic notification of UM decisions may be found in the web portal so it is the responsibility of the provider to check the portal regularly.

Authorization

Timeframes for completion of the clinical review are as follows:

Urgent—72 hours from the receipt of the request

Non-Urgent—14 calendar days

For urgent and non-urgent cases this period may be extended one time by the organization for up to 14 calendar days and may be requested by a member or a provider, provided that Trillium determines that an extension is necessary because of matters beyond its control; and notifies the member prior to the expiration of the initial 14 calendar-day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and If a provider agency fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the provider agency must be given at least 14 calendar days from receipt of notice to respond to the plan request for more information Prior-authorization for all services may be requested through submission of the Treatment Authorization Request (TAR) form. Enhanced Services require prior authorization; backdating is prohibited.

An expedited prior-authorization can be requested telephonically for any service, if immediate access is clinically indicated. If the caller established clinical necessity, the clinician verbally authorizes and reminds the provider to complete enrollment and submit the TAR.

An expedited request can be made in cases where adherence to the standard timeframe of 14 days for UM decisions could seriously jeopardize a members/recipient's life or health or ability to attain, maintain, or regain maximum functioning.

If the review of the TAR indicates the member's/recipient's situation meets Trillium established clinical criteria for the requested service, the UM Care Manager authorizes the service based on the Authorization Guidelines. The UM Care Manager generates an authorization letter which can be viewed by the provider in Provider Direct on the Print Authorizations link.

- **Peer Reviewer Definition**—The Medical Officer or a senior clinical staff person within UM or a Contractor with expertise in the area requested.

3. UM Care Manager decision outcomes are communicated and documented in the TBS system. Providers are responsible to check the TBS system on a regular basis to check on the status of the TAR and review any communications from the UM Department.

Any denial of service will follow the Medicaid-Appeals—Process procedure for Medicaid services and/or the—State-Funded Appeal—Process procedure for non-Medicaid services.

At the time of need for a continued authorization (no earlier than 30 calendar days prior to the expiration of the current authorization), the provider shall complete a TAR online and submit it electronically to Utilization Management via Provider Direct. The information required establishing the need for continued medical necessity and service continuation criteria must be included. The PCP/ISP review and/or update and other supporting documentation must be uploaded as part of the TAR submission.

Hospital Admissions

For members/recipients hospitalized on or after the effective date of enrollment in the waiver operated by Trillium.

Trillium will provide authorization for all covered services, including inpatient and related inpatient services, according to medical necessity requirements. Trillium shall provide authorization for all inpatient hospital services to members who are hospitalized on the effective date of disenrollment (whether voluntary or in-voluntary) until they are discharged from the hospital.

Registry of Unmet Needs

Trillium maintains a Registry of Unmet Needs to track requests for non-emergency services that have not been met through either state-funded or non-entitled Medicaid categories. The purpose of the Registry is to allow Trillium and providers to coordinate services for members/recipients. Inquiries about the registry of unmet needs can be sent to RUN@TrilliumNC.org.

Second Opinion

The right to a second opinion from a qualified health care professional within or outside the Trillium network, at no cost to the member. Upon request, Trillium shall provide one second opinion from a qualified health care professional selected by Trillium. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. Trillium shall not be required to provide the member with a third or fourth opinion.

Members are informed of the right to a second opinion in the Trillium Member and Recipient Handbooks, which is made available to them at the time of enrollment.

Decisions to Deny/Reduce/Suspend/Terminate a Medicaid Service

It is very important that providers understand the It is very important that providers understand the following rights so they may support the member's -request. A provider agency cannot appeal an action without the written consent of the member/parent/legal guardian to make the appeal on the member's behalf.

If the treating physician/practitioner/provider would like to discuss the case with the Trillium UM care manager or the physician/psychologist, referred to as a peer-to-peer conversation, please call the Provider Support Service Line at 1-855-250-1539.

There are times when a member's request for services is denied, and there are times when a current service is changed (i.e. terminated, reduced or suspended) by Trillium Utilization Management.

Detailed information about Due Process and Prior Approval Procedures can be accessed via the Division of Health Benefits (DHB) website. (See the Resources & Web Links section at the end of this Manual for website links.)

Denial

Denials could occur for administrative or clinical reasons.

A clinical denial could occur if the criteria are not met to support a new authorization request for a service. An administrative denial could occur if a request is determined to be an incomplete request or due to lack of information.

If the request does not meet the minimum requirements of the applicable clinical coverage policy (i.e., fails to include a PCP/ISP/treatment plan or other specific documents required by policy, including CCA, NC SNAP, Psychological Testing, LOCUS©/ CALOCUS©/ASAM, service orders) it is incomplete or lacks information and the request will be denied. A new request with the needed documentation may be submitted at any time.

The member/guardian will receive a letter by US Mail explaining the decision and how to request an appeal. If a Notice of Adverse Benefit Determination for Incomplete Request/ Lack of Information is issued, the notice will identify what information was missing from the request.

Reduction, Suspension, or Termination

Services a member is currently authorized for and receiving may be reduced, suspended or terminated at any point during the authorization period based on several different factors including not following clinical guidelines or not continuing to meet medical necessity for the frequency, amount, or duration of a service. A member/guardian or authorized representative will receive a letter by US Mail at least ten (10) days before the change occurs explaining how to request an appeal. If the member/guardian or authorized representative requests an appeal by the deadline stated in the letter, the services may continue through the end of the original approved authorization.

This does not apply for the denial of an initial service request.

Medicaid Services Appeal

Any member who does not agree with Trillium's Notice of Adverse Benefit Determination on a request for Medicaid services is entitled to appeal such determination through Trillium's appeal process. To begin the process, an appeal must be requested no later than sixty (60) calendar days from the mailing date of the Notice of Adverse Benefit Determination.

To request an appeal, an appeal request form may be completed and returned by fax, mail or in person, or the member/guardian or authorized representative may request an appeal orally. Trillium will acknowledge receipt of the appeal in writing within five (5) calendar days of receipt of the request. Upon request, Trillium

will provide the member/guardian or authorized representative the case/appeal file, including medical records, and any other documents and records pursuant to Trillium's Member Access to Protected Health Information Procedure free of charge, within two (2) calendar days of Trillium's receipt of the request.

An appeal review is an impartial review of Trillium's decision to reduce, suspend, terminate or deny Medicaid services. A health care professional who has appropriate clinical expertise in treating the member's condition or disorder, and who was not previously involved in the initial decision, determines the appeal decision.

Trillium will issue a decision in response to the request for appeal within thirty (30) calendar days from the receipt of the request for standard appeals and within seventy-two (72) hours from the receipt of the request for expedited appeals. The member/guardian/authorized representative must complete the internal appeal process with Trillium before requesting a hearing with the Office of Administrative Hearings (OAH), which is known as a State Fair Hearing.

Continuation of Benefits:

A. Trillium continues and pays for a Member's benefits during the pendency of the plan appeal and/or State Fair Hearing if all of the following occur:

1. The Member, or the Member's authorized representative, files a timely request for an appeal in accordance with federal regulations;
2. The appeal involves the termination, suspension, or reduction of previously authorized services;
3. The services were ordered by an authorized Provider;
4. The period covered by the original authorization has not expired; and
5. The Member timely files for continuation of benefits within ten (10) calendar days of Trillium sending the adverse benefit determination, or on the intended effective date of Trillium's proposed adverse benefit determination, whichever comes later.

B. If Trillium continues the Member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:

1. The Member withdraws the appeal or State Fair Hearing Request, in writing;
2. The Member does not request a State Fair Hearing and continuation of benefits within ten (10) calendar days from when Trillium mails an adverse Notice of Resolution;
3. A State Fair Hearing decision adverse to the Member is made.

Trillium does not allow a Provider to request continuation of benefits or request continuation of benefits on behalf of a Member.

If the final resolution of the Appeal is not decided in the member's/guardian's favor, Trillium may recover the cost of the services furnished to the member while the Appeal was pending.

Expedited Appeal Process

An expedited appeal may be requested by the member an authorized representative, or a provider requesting on the member's behalf if it is documented that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

For expedited appeal requests filed by providers on behalf of members, Trillium presumes an expedited appeal resolution is necessary and grants the request for an expedited appeal.

Trillium ensures that punitive action is not taken against a provider who requests an expedited appeal or otherwise support's a member's appeal. Expedited appeal requests may be filed orally or in writing with Trillium's Appeals Department. Oral requests for expedited appeal do not require written follow-up.

If an expedited request is received, it is reviewed to determine if there is sufficient evidence to support the need for this type of request. Additional documentation that the member/guardian or authorized representative wants to be reviewed should be submitted within one (1) calendar day of the date that the appeal request was filed.

If Trillium agrees that the appeal request qualifies for expedited processing, Trillium will complete the appeal within seventy-two (72) hours of Trillium's receipt of the appeal request. If there is not sufficient evidence to require an expedited request, the member/guardian will receive verbal notice of the denial of their request for an expedited appeal and written notice within two (2) calendar days and the appeal will follow the standard appeal timelines. If the member/guardian/authorized representative or provider disagree with the decision, they have the right to file a grievance regarding Trillium's decision to deny the expedited appeal request.

Extension of Timeframes for Expedited & Standard Appeal Process

Trillium may extend the timeframes for appeals resolution up to fourteen (14) calendar days if the member requests the extension; or Trillium shows that there is need for additional information and how the delay is in the member' best interest.

If Trillium extends the appeals timeframes, for any extension not requested by the member, written notice of the reason for the extension will be provided to the member/guardian or authorized representative by Trillium within two (2) calendar days. This notice will also inform the member of their the right to file a grievance if they disagree with the extension decision.

Medicaid Services Appeal Mediation

If a member/guardian or authorized representative is dissatisfied with the resolution of the appeal, the member/guardian or authorized representative may file a State Fair Hearing Request with the North Carolina Office of Administrative Hearings (OAH) within one-hundred twenty (120) calendars days from the date of the Decision on your Appeal Letter by submitting the State Fair Hearing Request Form to the addresses specified on that form. The telephone number for OAH is 984- 236-1860. A copy of the State Fair Hearing Request Form is attached to the Decision on your Appeal Letter. Once a State Fair Hearing Request has been filed with OAH, the Mediation Network of North Carolina will contact the member or the member's authorized representative to offer an opportunity to mediate the disputed issues between the member and Trillium in an effort to resolve the pending petition informally. The mediation process is voluntary.

If all issues are resolved at mediation, the State Fair Hearing request will be dismissed, and services will be provided pursuant to the Mediation Agreement. If the member or the member's authorized representative does not accept the offer of mediation or the results of mediation, then the petition may proceed to a hearing and the matter will be heard by an Administrative Law Judge (ALJ) with OAH. This is referred to as the State Fair Hearing Process.

The member or the member's authorized representative will receive notice from OAH of the date and time of the hearing.

If the member or the member's authorized representative disagrees with the Final Agency Decision, they may seek judicial review in Superior Court.

Member Ombudsman Program

The Tailored Plan's Ombudsman Program serves members across North Carolina, not just members in the Trillium catchment area. The Ombudsman Program is a neutral third party that educates members on their rights, answers questions about processes within the system, and works with appropriate agencies with resolutions of complaints and grievances.

The Ombudsman Program does not take the place of Trillium's process for filing an appeal.

Visit: ncmedicaidombudsman.org

or Call: **1-877-201-3750**

For questions concerning the decision Trillium made about the member's request for Medicaid services, please contact Trillium Health Resources Member & Recipient Services 1-877-685-2415. Should Questions about the State Fair Hearing process, please contact OAH or Trillium using the contact information listed.

North Carolina Office of Administrative Hearings (OAH)
Attn: Clerk
6714 Mail Service Center Raleigh, NC 27699-6700
Telephone: 1-984-236-1850
Fax: 1-984-236-1871

Trillium Health Resources
Appeals Department
201 W. First Street Greenville, NC 27858
Telephone: 1-866-998-2597
Fax: 1-252-215-6879

Non-Medicaid Service Appeal Process

Non-Medicaid services are not an entitlement. If a recipient/guardian or authorized representative disagrees with the non-Medicaid service decision, they may fill out the Non-Medicaid Service Appeal Form that accompanies the decision and return it to Trillium within fifteen (15) business days of the date of the Notice of Adverse Utilization Decision letter.

Trillium acknowledges receipt of a Non-Medicaid appeal with a letter to the appellant, dated the next working day following Trillium's receipt of the appeal. The non-Medicaid service appeal process maintained by Trillium provides an opportunity for the recipient, guardian, and authorized representative, ordering/treating provider and/or facility rendering service to submit information related to the case, including any documents, records, written comments, or other information that may be helpful in processing the appeal.

Peer Reviewers who process the appeal consider all the information received from the recipient, guardian, and authorized representative, ordering/treating provider and/or facility rendering service, regardless of whether the information was presented during the initial clinical review.

It can take up to seven (7) business days from the date the Non-Medicaid Service Appeal Form is received for a decision to be made by Trillium. The timeframe for processing the appeal begins at the date and time the request was received by Trillium.

If the appeal decision is to uphold the original Adverse Utilization Decision, the written appeal notification will explain that there is an opportunity for the recipient to appeal the decision to the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' Non-Medicaid Appeals Panel ("Non-Medicaid Appeals Panel), as well as the process for doing so.

Non-Medicaid Appeal Request to the Division

If a recipient/guardian/authorized representative disagrees with the non-Medicaid appeal decision, they may submit the Non-Medicaid Appeal Request Form to the Division.

The internal Trillium State-Funded Appeal process must be completed prior to filing the appeal request with the Non-Medicaid Appeals Panel.

The non-Medicaid appeal request is reviewed by the Non-Medicaid Appeals Panel. The Non-Medicaid Appeals Panel will issue its findings and decisions within sixty (60) days of receipt of the appeal request form to both the recipient/guardian and Trillium's CEO. Upon receipt of the Non-Medicaid Appeals Panel's findings and decisions, Trillium issues a final decision informed by thosefindings. Trillium issues the decision in writing within ten (10) calendar days of receipt of the panel's findings and decisions.

Receiving Services during the Non-Medicaid Appeals Process

Trillium has the option of authorizing other non-Medicaid Services that are appropriate. Services may be authorized for the duration of the appeal decision process at the discretion of Trillium.

Other community resources may also be referred to the recipient for support.

When a recipient/guardian/authorized representative files an appeal for the denial of a new service, Trillium is under no obligation to provide the requested service during the review process.

AA. CONTRACTS

The Contracts Department manages all contracts and procurement activities.

i. Procurement Contracts & General Conditions

Providers must enter into a Procurement Contract with Trillium before any services can be authorized, provided, and billed. The Trillium Combined Contract template is divided into two sections: a Procurement Contract and a set of General Terms and Conditions. This agreement outlines the requirements needed to remain in compliance according to federal and state regulations and Trillium's waiver participation. Providers that contract with Trillium must adhere to each section of the contract and appendices if they wish to remain a contracted provider in the Trillium Network.

Unsure about what sites and services are approved by your contract?

Log into your Provider Direct (PD):

Need to view your sites?

- Log into PD
- Select "Admin"
- Select "Provider Management"
- This screen will display the Master Site at the top of the list, followed by each sub-site approved by the contract.

Need to view your services?

- Log into PD
- Select "Admin"
- Select "Provider Management"
- This screen will display the Master Site at the top of the list, followed by each sub-site approved by the contract.

For contract questions and concerns, please contact Network Services Support at NetworkServicesSupport@TrilliumNC.org or call Trillium's Provider Support Service Line at 1-855-250-1539.

Trillium's responsibility to Providers related to contracts is to:

- Send written correspondence via USPS mail or email as needed
- Provide technical assistance as needed related to Trillium's contract requirements and Provider Manual requirements
- Respond to provider inquiries and provide feedback in a timely manner

BB. PROVIDER TRAINING

The Training Department identifies training needs and coordinates all training for the provider network. The team collaborates with various groups for input and feedback, including Trillium staff, Provider Network, Consumer and Family Advisory Committees (CFACs), Provider Council (PC) and Clinical Advisory Committee (CAC.) The Provider Training Unit also partners with staff, providers, stakeholders and community partners to develop training around special Trillium initiatives or categories of topics.

Trillium is committed to offering ongoing training opportunities to network providers as a mechanism to maintain professional competence and remain up to date with changes that occur in the behavioral health-care industry. The Trillium Training Department implements a training plan that is reviewed and updated annually.

Trillium's Training Department manages an online learning platform that has multiple trainings available on demand. Any active provider in the Trillium network is eligible to sign up for our online learning platform. Vital trainings such as our New Trillium Provider Orientation and all of our Provider Direct trainings can be found and accessed 24 hours a day, 7 days a week, 265 days a year. We regularly update and add to the list of trainings available on the online learning platform.

To sign up for our online learning platform, please complete the Learning Campus Agreement form found here:

Trillium Learning Campus Agreement

Trillium's responsibility to Providers related to training is to:

- Identify training needs and provide training and technical assistance to the provider/practitioner network.
- Keep network providers informed through provider meetings, electronic updates, notifications and the Trillium website.

CC. PROVIDER NETWORK

i. Network Management Department

The Network Management Department is responsible for the development and maintenance of the provider network to meet the needs of members and recipients while ensuring choice and best practices in services. The department includes: Provider Relations and Engagement, Network Auditing, Practice Management, Provider Data Management, Contracts Monitoring, Contracts, Network Development Provider Enrollment, and Tailored Care Management-Provider Network.

ii. Network Auditing

The Network Auditing Team handles provider monitoring and auditing activities. Common review activities include but are not limited to provider monitoring reviews, post payment reviews, and initial/annual site visits.

Quality Monitoring

Our responsibility is to assure the quality of services provided by the Trillium provider network. Trillium is accountable to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Health Benefits (DHB) in the management of both State and Medicaid services.

In addition to state requirements, Medicaid Waiver quality requirements are extensive and include:

- Health and safety of members
- Rights protection
- Provider qualifications
- Member satisfaction
- Assessment of outcomes to determine efficacy of care management of care for Special Needs Populations
- Preventive health initiatives
- Clinical best practice

Provider Monitoring

Trillium utilizes a standard Provider Monitoring process to ensure high quality services for individuals.

It is the vehicle used for entry into the provider network and the evaluation of service providers against quantitative and qualitative measures using monitoring tools developed by Trillium. The standard Provider Monitoring process is used to monitor both Medicaid and State-funded behavioral health, I/DD and TBI services.

Carolina Complete Health and the pharmacy benefit manager will be involved in quality monitoring and provider monitoring.

This section does not discuss other types of audits and investigations Trillium may conduct, such as Program Integrity investigations, complaint and grievance investigations and post-payment clinical reviews.

All contracted providers will participate in the Provider Monitoring process, on a schedule developed by Trillium.

All Provider monitoring will be conducted using tools developed by Trillium, which are made available to providers (or its subcontractors) on the Trillium website. (See the Resources & Web Links section at the end of this manual for the link.)

The selection of tools is determined by both the type of provider and the array of services they render to Trillium members and recipients.

Trillium will share comprehensive after completion of the review findings.

Documentation will outline areas reviewed, scores achieved, and required follow-up. Any monitoring tools can be used at any time for targeted monitoring or investigations

For Licensed Independent Practitioners (LIPs), Provider Monitoring includes the NC DHHS Review Tool for LIPs and the LIP Post-Payment Review Tool.

Home and Community-Based Services (HCBS)

Home and Community-Based Service Assessments must be submitted when requesting the following services:

Supported Employment Services, Initial Supported Employment, Residential Supports, Day Supports, and Day Supports Developmental Day.

The HCBS Provider Self-Assessment can provide additional guidance to all Home and Community-based Services final rules.

For questions concerning Home and Community-based Services assessments email HCBSTransplan@dhhs.nc.gov or hcbs@TrilliumNC.org.

Practice Management

The Practice Management team is responsible for leading Trillium's development of performance and value-based payment strategies. Our Practice Management team develops and leads innovative strategies to increase the use of value-based purchasing arrangements that will assist the organization in providing quality, effective, personalized, whole-person care to the members we serve. Our Practice Management Consultants work directly with our network of providers to lead performance improvement projects, identify performance measures, track member outcomes and enhance service delivery. The Practice Management team assists in the development and growth of our provider network, recruitment and retention of high-performing providers, training, and education. This team works with providers to identify priority areas and domains needed by providers to participate in alternative payment arrangements in the delivery of care, across all populations that Trillium serves. Clinical Practice Guidelines can be found on our website.

Provider Service Support

The Provider Service Support Team supports network providers by addressing provider concerns and questions through the Provider Support Service Line or the Network Services Ticket System.

Providers may call Trillium's Provider Support Service Line at 1-855-250-1539 with questions, inquiries and issues to receive a "one touch" resolution. The Provider Support Service team, comprised of knowledgeable customer service professionals, will interact with providers directly to assist with provider needs

A helpdesk ticket is created when a provider emails NetworkServicesSupport@TrilliumNC.org. This ticket number will be used for further correspondence and reference.

Other Provider Service Support activities include but are not limited to:

- Providing telephonic and email support to providers.
- Sharing Provider Welcome Packets and enrollment notices.
- Initiating surveys and interviews with providers to facilitate program evaluation.
- Service delivery.

iii. Types of Providers

Agency-Based Providers

An agency-based provider is an entity organized as a corporation, limited liability company, or other designation overseen by the NC Secretary of State, either for-profit or not-for-profit, engaged in the provision of services covered by Trillium. Employees of the agency provide the services to the member/recipient, and agency management assures that the employees meet the qualifications to provide services and that all other requirements of the contract between PIHP and the agency-based provider are met.

State-Operated Health Care Facilities

North Carolina oversees and manages 14 state-operated healthcare facilities that treat adults and children with mental illness, I/DD, substance use disorders and neuro-medical needs.

Licensed Independent Practitioners and Professional Practice Groups

Licensed practitioners in the areas of psychiatry, psychology, and social work are enrolled in Trillium's provider network. Licensed practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy.

Practitioners may work for an agency-based provider (LP) or may directly contract with Trillium (LIP). Members are offered a choice of LIPs or agency-based providers when calling the Member and Recipient Services line and requesting evaluation or outpatient treatment services.

Hospital Facilities

Hospitals with inpatient psychiatric facilities and/or outpatient psychiatric programs are also enrolled in the network.

Hospitals that provide Emergency Services to members with a behavioral health discharge diagnosis are paid for these services under an out of network agreement.

Advanced Medical Home Plus (AMH+)

Primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Behavioral Health I/DD Tailored Plan eligible population, or can otherwise demonstrate strong competency to serve that population and have certified by the State or BH/IDD Tailored Plan.

Care Management Agency (CMA)

Provider organization with experience delivering behavioral health, I/DD and/or TBI services to the Behavioral Health I/DD Tailored Plan-eligible population that will hold primary responsibility for providing integrated, whole-person care management to Tailored Plan members assigned to it, under the Tailored Care Management model as certified by the State or Tailored Plan.

Primary Care Providers (PCP)

A primary care provider (PCP) is the participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the member's health care needs and to initiate and monitor referrals for specialized services when required. The PCP serves as the "medical home" for the beneficiary. The "medical home" concept assists in establishing a beneficiary/provider relationship, supports continuity of care and patient safety, leads to elimination of redundant services, more cost effective care and better health outcomes.

Primary care provider (PCP) is a doctor, nurse practitioner, physician assistant or other type of provider who will:

- Care for the member's health
- Coordinate the member's needs
- Help the member get referrals for specialized services if needed

Each family member enrolled in Trillium can have a different PCP, or members can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. If a member needs help selecting a PCP, please have them call Member and Recipient Services at 1-877-685-2415.

Women can choose an OB/GYN to serve as their PCP. Women do not need a PCP referral to see a health plan OB/GYN doctor or another provider who offers women's health care services. Women can get routine check-ups, follow-up care if needed and regular care during pregnancy.

If a member has a complex health condition or a special health care need, they may be able to choose a specialist to act as their PCP. In order to select a specialist as their PCP, the member should call Member and Recipient Services at 1-877-685-2415.

Medicaid members have opportunity to choose their own PCP. If they do not select a PCP, Trillium will choose one for the member based on their past health care. The PCP's name and contact information will appear on the member's Medicaid card. If a member would like to change their PCP, they will have 30 days from the date of receipt of their member welcome packet. After that, members can change their PCP only one time each year without cause.

To change a PCP assignment more than once a year, a member must have a good reason (good cause).

Examples of good cause include:

- The PCP does not provide accessible and proper care, services or supplies (for example, does not set up hospital care or consults with specialists when required for treatment).
- The member disagrees with their treatment plan.
- The PCP moves to a different location that is not convenient for the member.
- The PCP changes the hours or days that patients are seen.
- The member has trouble communicating with the PCP because of a language barrier or another issue.
- The PCP is not able to accommodate the member's special needs.
- The member and the PCP agree that a new PCP is what is best for their care.

Advanced Medical Home (AMH)

Advanced Medical Home refers to an initiative under which a Standard Plan or Behavioral Health 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.

- Accept members and be listed as a PCP in Trillium's member-facing materials for the purpose of providing care to members and managing their healthcare needs.
- Provide primary care and patient care coordination services to each member, in accordance with Trillium policies.
- 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.
- Provide direct patient care a minimum of thirty (30) office hours per week.
- Provide preventive services as required.
- Maintain a unified patient medical record for each member following Trillium's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or Trillium (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.
- Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by Trillium's network adequacy standards.
- Refer for a second opinion as requested by the member, based on Department guidelines and Trillium standards.
- Review and use member utilization and cost reports provided by Trillium for the purpose of AMH-level UM and advise Trillium of errors, omissions or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by Trillium for the purpose of participating in Trillium or practice-based population health or care management activities.

Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners, Internal Medicine physicians, Nurse Practitioners and Physician Assistants. The PCP may practice in a solo or group setting or at a FQHC, RHC or outpatient clinic. Trillium may allow some specialists to serve as a beneficiary's PCP for beneficiaries with multiple disabilities or with chronic conditions as long as the specialists agrees, in writing, and is willing to perform the responsibilities of a PCP as stipulated in this Manual.

Pharmacy

Trillium provides pharmacy benefits through its Pharmacy Benefit Manager. Trillium adheres to the State Preferred Drug List (PDL) to determine medications that are covered under the pharmacy benefit, as well as which medications may require prior authorization.

DD. NETWORK DEVELOPMENT

Trillium will ensure the provision of covered services as specified by the North Carolina Department of Health and Human Services (NCDHHS). Trillium will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the needs of Medicaid members, Medicaid Direct members, and State-funded recipients, including adults and children, without excessive travel requirements, that is in compliance with Trillium access and availability requirements.

Trillium maintains an open network for all primary care, physical health, and pharmacy service providers offering Medicaid services to Tailored Planmembers. Trillium will negotiate with any willing provider in good faith regardless of provider or Tailored Plan affiliation. Trillium maintains a closed network for behavioral health, substance use, intellectual/developmental disability or traumatic brain injury services as set forth in N.C. Gen. Stat. § 108D-23. Trillium will include in its network all essential providers for behavioral health, I/DD, and TBI services located in the region regardless of closed network requirements for Medicaid, Medicaid Direct, and State-funded services.

i. Primary Care and Specialists

Trillium offers a network of primary care providers to ensure every Tailored Plan member has access to a medical home within the required travel distance standards. Physicians who may serve as PCPs include Internists, pediatricians, obstetrician/gynecologists, family and general practitioners, nurse practitioners, and physician assistants.

In addition, Trillium will have available, at a minimum, the following specialists for Medicaid members on at least a referral basis:

- Allergy
- Dermatology
- Family Medicine
- General Practice
- Internal Medicine
- Cardiology
- Endocrinology
- Obstetrics
- Ophthalmology
- Optometry
- Orthopedics
- Otolaryngology
- Pediatric (General)
- Pediatric (Subspecialties)
- Physical Medicine and rehab
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Pulmonary Disease
- Rheumatology
- Neurology
- Podiatry
- Psychiatrist-Adult/General
- Psychiatrist-Child/Adolescent
- Psychologist/Other Therapies
- Surgery/General
- Urology
- Vision Care/Primary Eye care

In the event that the Trillium network is unable to provide medically necessary services required under the contract, Trillium shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

ii. Provider Communication

Trillium is committed to keeping network providers well-informed of State or federal changes, new information, trainings, requests for proposals, and opportunities for collaboration. Trillium's website offers links to a variety of web-based resources. Trillium disseminates critical and/or time-sensitive information through the Network Communication Bulletins and/or Clinical Communication Bulletins. If you do not currently receive these email notifications, please sign up by choosing the Network Provider List.

Provider Representation

Trillium also has incorporated provider representation into numerous aspects of our operations to offer the opportunity for input and feedback regarding things that affect network providers, including:

- Provider Council (see more information below)
- Clinical Advisory Committee
- Global Quality Improvement Committee
- Ad hoc work group (i.e., groups that are designated for a specific assignment)

iii. Provider Council

The mission of the Trillium Provider Council is to serve as a fair and impartial representative of all service providers within the network. The Provider Council facilitates an open exchange of ideas; shares vision, values and goals; and promotes collaboration and mutual accountability among providers. The Provider Council strives to achieve best practices to empower members within our community to achieve their personal goals.

The Provider Council's objectives are to:

- Review network performance against stated goals.
- Review and make recommendations to Trillium regarding performance indicator selection and performance issues, including outliers.
- Review quarterly reports on referrals made/referrals accepted per service per provider; members receiving services per provider; discharges from providers and reasons; and annual review of trend analysis.
- Recommend new service initiatives to address service gaps.

- Assess and provide for staff education and training needs assess community and prevention needs.
- Develop strategies to address funding and financial issues.
- Approve the provider satisfaction survey and review results with recommendations.
- Review and provide input to the Trillium Cultural Competency Action Plan.
- Advise the Chief Executive Officer regarding provider contract reconsiderations, upon the request of the Chief Executive Officer.

The Provider Council is a key Trillium committee. The Provider Council membership is designed to reflect the diversity of the network. The Council represents the interests and challenges of the network providers. This committee also reviews and makes recommendations regarding network management policies, accreditation standards, key performance indicators, service initiatives and requirements. Minutes from Provider Council meetings are posted on the Trillium website.

iv. Reporting of Disciplinary Actions

All disciplinary actions based on professional competency or conduct which would adversely affect clinical privileges for a period longer than 30 calendar days or would require voluntary surrender or restriction of clinical privileges, while under, or to avoid, investigation is required to be reported to the appropriate entity (i.e., State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, etc.) Upon the direction of the Trillium Medical Officer, the Network Department will be responsible for notifying all appropriate entities including State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, and the appropriate licensing bodies within 15 business days of the final determination.

v. Applying for Additional Services

Consideration Criteria

There are three main criteria that need to be met before a provider is eligible to add additional Behavioral Health, , I/DD, TBI, or State-Funded Services:

- Provider must be active and enrolled with NC Tracks and North Carolina Medicaid; and
- Trillium has established there is sufficient need for the service(s); and
- Any sanctions and/or the submission of a Plan of Correction (POC), follow-up review and/or established wait period following satisfactory implementation of a Plan of Correction—must be completed and verified by Trillium.

Please see RFPs/RFAs posted on our website for needs/gaps in our network. To make contract requests outside of the RFPs/RFAs, please email NetworkServicesSupport@TrilliumNC.org for further consideration.

vi. Plan of Correction Process

A Plan of Correction (POC) is a tool used to describe a plan of how issues that have been found to be out of compliance will be corrected. It is a method for describing how the provider will immediately correct identified problems. It is also a method for identifying the systemic root cause of the problem and what system changes are needed to prevent the problem from reoccurring in the future.

A POC may result from any review or monitoring that finds systemic or programmatic issues that are in violation or contrary to Federal, State, or local law, Provider Contract, Provider Manual, or the agency's own policies/procedures. A POC may also be the result of an investigation of a complaint or allegation which also results in out of compliance findings. In cases where the issue is outside the scope of Trillium, Trillium will determine the appropriate point of referral for the issue or circumstance observed. Such referrals may be made to the Division of Health Service Regulation, the Department of Social Services, the Division of Health Benefits, the Department of Labor, the appropriate DMH/DD/SAS team or other appropriate agency.

POCs are requested in writing via a letter on Trillium letterhead sent via secure e-mail with a return receipt. The POC request letter will inform the provider of where and how to submit the POC. The POC template can be found on the Trillium website. (See the Resources & Web Links section at the end of this Manual for the link to this document.)

All Trillium POCs are submitted via secure e-mail to the Department requesting the POC. The POC will be due to Trillium within 15 calendar days of delivery or attempted delivery of the request letter. If the POC is accepted, it is considered to be appropriate and contains all of the required criteria. The provider will be notified in writing of the POC acceptance within 15 calendar days and a follow-up monitoring will be scheduled no more than 60 days from the acceptance date.

If the POC is not accepted, the provider will be notified in writing of its non-acceptance within 15 calendar days.

The letter will specify what corrections are needed for the second—and final—POC to be accepted.

The provider has ten calendar days to revise the POC and resubmit it in full to the Tailored Plan. Once received, the final POC is reviewed by the designated Trillium department.

If the final POC is accepted, the provider will be notified in writing of the POC acceptance within 15 calendar days and a follow-up monitoring will be scheduled no more than 60 days from the acceptance date. If the final POC is not accepted, the matter will be submitted to the appropriate personnel for further review and potential imposed sanction(s). Criteria used to review the POC can be found in NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plans of Correction (POC.) See the Resources & Web Links section at the end of this Manual for the link to this document.

If a provider does not submit a POC within the required time frames, a reminder letter will be sent, including the consequences of failure to submit a POC. If there is still no response within ten days of attempted delivery of the final request letter, it will be treated as a non-accepted POC. Failure to respond and submit a POC will result in termination of contract for service(s.)

Follow-Up Review

No later than 60 calendar days following the date the POC is approved or accepted a Monitoring Review Team will follow-up to ensure the POC has been implemented and the identified out-of-compliance findings have been corrected. The provider will be notified in writing and by fax of the follow-up review at least seven calendar days in advance.

At the first follow-up, if the reviewers determine that the POC is being followed and the issues have been corrected, the team will designate the action closed. If the department determines that the POC is not being followed and/or the issues have not been corrected, a second and final follow-up review will be required.

The provider will be notified in writing of the need for the second follow-up. In approximately 20 calendar days following receipt or attempted delivery of the "additional follow-up required" letter, a Monitoring Review Team will follow-up to ensure the POC has been implemented and the identified out-of-compliance findings have been corrected. If the reviewers determine that the POC is being followed and the issues have been corrected, the team will designate the action closed. If the issues are still not resolved, the matter will be submitted to the appropriate personnel for further review and potential imposed sanction(s). For additional information related to POCs, please go to My Learning Campus to view a training on Plans of Correction. (See the Resources & Web Links section at the end of this manual for the link.)

Trillium's Responsibility to Providers related to Network Development is to:

- Review the provider's performance record for any quality citations, actions that resulted in suspension of referrals, Division of Health and Safety Regulation (DHSR) findings, as well as demonstrations of quality and best practice.
- Send written correspondence via secure e-mail as needed.
- Provide technical assistance as needed related to: Trillium contract requirements; Trillium Provider Manual requirements; the development of appropriate clinical services; quality improvement initiatives; or to assist the provider in locating sources for technical assistance.
- Respond to provider inquiries and provide feedback in a timely manner.

- Assist providers in understanding and complying with Trillium policies and procedures, applicable policies and procedures of the NC Department of Health and Human Services and federal agencies, as well as the requirements of our accreditation agencies.
- Actively recruit network providers with a mission and vision consistent with Trillium.
- Support the development and support of best practices or emerging best practices.
- Identify gaps in network services and develop a strategy to develop those services through existing providers or by recruiting new providers for the network.
- Notify the provider of the Trillium's decisions regarding network participation via secure e-mail.
- Maintain an up-to-date Network database.
- Notify providers in writing of Trillium's decision regarding requested leaves of absence.
- Provide evaluative feedback relative to proficiency in providing culturally competent services.

EE. QUALITY MANAGEMENT (QM)

Trillium's Quality Management Program description is also called the Quality Management and Improvement Program (QMIP). This is the foundation of Quality Management (QM) throughout Trillium. The QMIP was developed to align with the critical needs of our population and meet the requirements as set forth by NCDHHS. Trillium seeks to improve health outcomes for Medicaid members/State-funded Recipients (members) by focusing on rigorous and well-defined outcomes measurements, promoting health outcomes for all diverse populations we serve through reduction or elimination of health disparities, and rewarding providers for advancing quality goals. Our QMIP addresses the integrated health needs of our members with the goal of improving access to care and meeting the needs of all members, regardless of age or health condition.

In alignment with NC's quality strategies, the overarching purpose of Trillium's Quality Program is focused on whole person-centered care that supports:

- Better care delivery and improved member experience
- Healthier people, healthier communities
- Improved provider experience
- Smarter spending

Within the organization, quality assurance is used as the foundation for quality improvement and provides information in guiding the improvement process.

Information from quality improvement activities is utilized as a platform for data reporting and analysis and provides the opportunity for organizational planning and informed decision-making. Quality improvement within the organization not only focuses on adhering to standards and statutory requirements, but also serves as the mechanism for emphasizing the agency's commitment to excellence.

In a system driven by continuous quality improvement, the QMIP facilitates the objective and systematic measurement, monitoring, and evaluation of internal organizational processes as well as services delivered by network providers. Performance Improvement

Projects (PIPs) can be implemented as a result of the findings from these activities and measured periodically for intervention effectiveness.

The QM Department makes training available to the provider network. Trillium is committed to working in collaboration with providers to aide and assist them with achieving the highest standards of quality in service delivery. The important role of quality management in protecting members/recipients and promoting high-quality treatment is understood and valued.

A strong commitment to continual improvement of programs and services, as well as the services provided directly to members is maintained. Trillium providers are required to maintain a Quality Management Program that is comprehensive and proactive. The areas identified below provide a description of how the Trillium Health Resources QM Department interfaces with the providers in the network. Trillium communicates activities and outcomes of its QMIP to members and providers/practitioners through Trillium's website. The Quality Assurance and Performance Improvement (QAPI) I Work Plan monitors quality related tasks and goals established in the QMIP.

i. QM Indicators

Trillium is required to comply with numerous quality, satisfaction, performance indicator and financial reporting requirements under our DHB and DMH/DD/SAS contracts, including requirements to measure and report indicators. Trillium provides ongoing monitoring of Healthcare Effectiveness Data and Information Set (HEDIS) measures and key performance indicators (KPIs) to assure practitioners and providers are meeting and maintaining identified performance benchmarks.

In addition, Trillium's role as a Tailored Plan is to monitor the performance of providers in its network. QM is responsible for monitoring provider incident reports, administering surveys, policy and procedure management and tracking, facilitating root cause analyses, collaborating internally on accreditation standards and various other projects and tasks.

It is expected that network providers perform continual self-assessment of services and operations, as well as develop and implement plans to improve member outcomes. The continual self-assessment of services and operations, as well as the development and implementation of plans to improve outcomes to members, is a value and requirement for all network providers. The assessment of need as well as the determination of areas for improvement should be based on valid and reliable data.

Providers are required to follow all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the provider contract and provider manual.

The Performance Measures Unit, with the assistance of the Informatics Unit in IT leads the analytic function for support of the continuous quality improvement efforts of the agency and for discerning opportunities for identifying and responding to areas of operational need. Included in this is the implementation of drill down analytics which provides the opportunity to discover disparities in quality metrics and to understand variation in quality across various venues of performance.

These investigative analytics lead to an understanding of what is driving gaps in services and aid in identifying areas for improvements in order to enhance the overall quality of care for Trillium members/recipients. Trillium uses the information discovered to guide policy decisions and annual improvement goals.

ii. Healthcare Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used set of performance measures in managed care. HEDIS measures related to behavioral health, physical health and pharmacy data are monitored on a routine basis to ensure the identified benchmarks are being met. Trillium uses the information discovered to guide policy decisions and annual improvement goals.

Data is shared with providers on a routine basis. Trillium will utilize dashboards and reports to monitor measures internally and externally with providers to identify areas for improvement and appropriate interventions.

FF. COMMITTEE STRUCTURE

Trillium's Governing Board has ultimate authority for the oversight of Trillium's Quality Program and has established various committees and sub-committees to monitor and support the QM Program. The consortium of committees report to one main committee, the Quality Improvement Committee (QIC). Trillium recognizes the role providers' and practitioners' involvement has in the success of the Quality Program. Involvement in various levels of the process is highly encouraged through provider/ practitioner representation on key quality related committees such as, but not limited to, Global Quality Improvement Committee, Provider Council, Clinical Advisory Committee and Human Rights Committee.

Trillium supports the following committees that report to the QIC on a scheduled basis:

- Global Quality Improvement Committee
- Human Rights Committee
- Clinical Advisory Committee
- Provider Council
- LTSS & I/DD/Innovations Wavier Member Advisory Council
- Health Equity Council

i. Global Quality Improvement Committee

The Global Quality Improvement Committee (GQIC) serves as a fair and impartial committee representing the practitioners/providers network to discuss and explore ideas related to Quality Improvement issues.

Participants of this Committee consist of an array of practitioner/provider representatives in addition to Trillium Health Resources staff.

In addition to practitioner/provider representatives, the committee membership also includes representatives from the Regional Consumer and Family Advisory Committees (CFAC). The goal of the GQIC is to represent collaboration and strengthen the relationship between practitioners/ providers and Trillium Health Resources. The GQIC discusses and monitors the quality needs of the network and identifies recommendations from the committee members to the QIC as appropriate and necessary.

The QIC has ultimate decision-making authority regarding recommendations and initiatives. Trillium staff serve as liaisons to the committee and act as administrative support to the committee. The GQIC liaison regularly makes reports to the QIC.

The objectives of this committee include:

1. Review quality concerns developing in the Network.
2. Assess training needs of the network related to quality.
3. Collaborate with Trillium QM staff regarding quality issues and learn about the LME/ MCOs Quality Assessment and Performance Improvement Plan, quality related activities and other quality related initiatives.
4. Participate in the selection, monitoring and discussion of Trillium Performance Improvement Project topics and the formulation of project goals.
5. Review current standards and provide suggestions and feedback for improving QA/QI systems.
6. Allow for avenues in which providers can learn from each other.

Email QMinfo@TrilliumNC.org if interested in engaging in the 'Confidential Peer Review' process.

Information from this committee can be found on the Trillium website and is shared in Network Communuication Bulletins. If there is interest in participating in the Global Quality Improvement Committee, please email QMinfo@TrilliumNC.org.

ii. Human Rights Committee

The Human Rights Committee (HRC) is a provider led committee comprised of board representation, member/recipient family members and practitioners/ providers representing all disability groups. Members are appointed by Trillium's Governing Board, or a designee. Trillium staff serve as liaisons to the committee. HRC plays a vital role by ensuring the protection of member/recipient rights for people receiving mental health, substance use and intellectual and/ or developmental disability services. The

Committee is responsible for the monitoring and oversight of the use of restrictive interventions, members' and recipients' rights violations, and incidents of abuse, neglect and exploitation, grievances, complaints.

The primary responsibility of the committee is to ensure the protection of members' rights by reviewing:

- Complaints and grievances regarding potential member/recipient rights violations.
- Concerns regarding the use of restrictive interventions by providers.
- Concerns regarding confidentiality.
- Concerns regarding member/recipient incident reports.
- Critical Incidents that involve the use of restrictive interventions, allegations of abuse, neglect, or exploitation against a staff member or facility, and member deaths.
- Concerns related to quality of care, accessibility, health and safety, lack of crisis responsiveness.
- Alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation brought by members, advocates, parents or other legally responsible person, staff or community stakeholders.

iii. Clinical Advisory Council

Trillium's Chief Medical Officer (CMO) brings together clinical leadership from external multi-specialty groups from the Network including our SP and Pharmacy Benefits Manager (PBM) partners, as part of the Clinical Advisory Committee. This Clinical Advisory Committee provides input into the clinical decisions and clinical practice guidelines used by Trillium, our SP, and PBM partner(s). The goal of the Clinical Advisory Committee is to identify clinical practices that are likely to improve clinical quality outcomes and enhance member experience. This group serves to promote evidence-based practices for all populations served within the network. The Clinical Advisory Committee facilitates an open exchange of ideas, shared values, goals, a vision, and promotes collaboration and mutual accountability among practitioners/providers. The Clinical Advisory Committee strives to achieve best practices to empower members within our community to achieve their personal and health goals. The Clinical Advisory Committee reviews and provides input into the selection of evidenced-based clinical practice guidelines relevant to members and based on literature review. The Clinical Advisory Committee will review the monitoring of adherence to selected elements of the guidelines and provide feedback and assistance to practitioners/providers as needed. All voting members of the committee must be representatives of the specialties in Trillium's Network as defined in the contract between Trillium and the state of NC and are licensed pharmacists/physicians/ medical doctors and/or clinicians (practitioners/ PhD/ PsyD), including the CMO of Trillium with the exception of qualified I/DD professionals. The Clinical Advisory Committee offers an opportunity for involvement of representatives of external relevant medical systems (hospitals) and other physical health care practitioners/groups in the quality improvement program. Consideration for membership is evaluated routinely in order to maintain a committee that represents a diversity of community providers. The CMO functions as the liaison to QIC and makes regular reports on activity.

The objectives of this committee are to:

- Provide feedback and recommendations to Trillium about its clinical initiatives and clinical performance.
- Recommend new service initiatives to address service gaps and provide insight into the annual Network Development Plan.
- Recommend clinical training and clinical education for the Trillium clinical network.
- Evaluate and recommend clinical practice guidelines, along with approaches for monitoring their implementation in Trillium network practices.
- Review and advise Trillium regarding the annual QMIP Description, and to review the goals, and objectives of the Trillium Quality Program.

- Review, provide feedback, and monitor progress of Trillium's performance improvement projects and outcomes for meeting performance goals.
- Review and advise Trillium regarding the annual Utilization Management (UM) Plan, and to review the goals, and objectives of the Trillium UM department.

iv. Provider Council

The Trillium Provider Council (PC) strives to be knowledgeable of all aspects of Trillium operations that impact practitioners/providers, including network capacity, stability and the quality of care that its members provide. The PC relies on an exchange of information from its membership and input from other committees. The PC meets quarterly and represents the practitioner/provider community. It represents the interests and needs of the network and identifies strategic issues that affect the performance of the network. The PC offers an opportunity for involvement of representatives of relevant behavioral health medical systems and other health care practitioners into Trillium's quality improvement program.

Responsibilities of the PC include efforts to promote standardization and consistency throughout the system and to advise Trillium on the impact that changes in the system have on members and practitioners/providers/practitioners. The Council membership includes practitioners/providers representing various services, member/family members and Trillium staff.

The Trillium Provider Council:

- Serves as a fair and impartial representation of all service providers within the network.
- Identifies strategic issues that impact network performance.
- Facilitates an open exchange of ideas.
- Shares values, goals and vision.
- Promotes collaboration and mutual accountability among the network.
- Recommends best practices that empower members to achieve their personal goals.

v. LTSS/IDD

The purpose of the LTSS & I/DD-Innovations Waiver Member Advisory Council (Member Advisory Committee-MAC) is to solicit provider and member advocate input into the approach and effectiveness of Trillium's associated programs, policies, and services, and to engage in a collaborative effort to enhance and promote an outcomes-based service delivery system in local communities. The Council promotes two-way communication between members/member advocates and providers/provider associations where all parties can provide input and ask questions and Trillium can ask questions and obtain feedback.

The LTSS & I/DD-Innovations Waiver Member Advisory Council consists of members/recipients/parents/guardians/caregivers, member advocacy organizations, LTSS/I/DD/Innovations Waiver providers/provider associations, and Trillium staff, as appropriate, that reviews and reports on a variety of quality and service issues to positively affect program operations. This Council will have varied representation with some members of the group having served on other Trillium committees or work groups. Specific state and contract requirements can be found in the QAPI Work Plan.

The primary responsibilities of the Council are to:

- Discuss and articulate positions and offering input or feedback on relevant topics that shape support/services.
- Review and discuss topics such as member satisfaction results, associated service key performance indicators, service utilization, policy and legislative initiatives, program initiatives and implementation with members, and member education materials.
- Make recommendations related to program enhancements based on the needs of the membership, providers, and local communities.
- Make recommendations related to quality measures and health plan initiatives for members receiving services.
- Provideing feedback to Trillium regarding member satisfaction and experience survey results.

- Assist in identifying key issues related to programs that may specifically affect members and providers.
- Provide community input on potential service improvements.
- Offer effective approaches for reaching or communicating with members.

vi. Health Equity Council

Trillium's Health Equity Council is made up of representatives from several different established groups and local stakeholders and reports to the CEO quarterly including recommendations. The council members reflect the diverse populations served by Trillium. The Health Equity Council is staffed by the Chief Operations Officer, Vice President of Member Solutions, Associate VP of Operations, Vice President of Network Management, Regional Directors, Executive Vice President of Care Management and Population Health and Senior Data Analyst of Strategy and Innovation. Trillium's Health Equity Council is a 20 member council.

The Trillium Health Equity Council convenes monthly and reports to the CEO quarterly. The Council members focus on the following:

- Improved Health Access by identifying and analyzing health disparities through review of utilization and quality data.
- Address stakeholder representation and engagement in improvement initiatives.
- Identify areas for improving diversity of staff, especially those in leadership positions, serving NC Medicaid members.
- Improved Health and Education Outcomes including the annual review and approval of the Member Engagement and Marketing plan for historically marginalized populations.
- Increases health promotion through new initiatives that address health disparities and promote health awareness and health literacy campaigns, events and activities in local communities including inclusion and acceptance campaigns to remove stigma related to mental illness, addiction, and intellectual and developmental disabilities.
- Increased Health Equity- our health equity grows from social, political, and economic equality for all. Trillium's Health Equity Council will work to not just promote efforts for health equity but also to identify, examine and promote the dismantling of policies, systems, and environments that lead to inequities.

The Health Equity Council is convened by Trillium's Director of Health Equity. Information is shared throughout Trillium enterprise and incorporated in other facets of organizational development and design.

Information related to this committee is shared in Network Communication Bulletins and posted on the Trillium website. Providers should adhere to APSM 95-2 regarding clients' rights. If there is interest in participating in the Human Rights Committee, please email QMinfo@TrilliumNC.org.

vii. Provider Performance Data

Trillium shares provider-specific performance data at least annually to support ongoing adherence to quality standards. Trillium provides data to practitioners/ providers including interpretation of their QI performance data and feedback regarding QI activities. This offers providers a snapshot into how they are performing in certain areas compared to similar network practitioners/providers. These reports may include performance data related measures, HEDIS measures, Value Based Purchasing metrics, among other measures.

Trillium utilizes various methods to gather and distribute performance and quality related data to providers. Sharing of this information creates transparency, promotes provider accountability, enhances provider internal processes, and supports continual quality improvement for the network.

This data may be used for comparative purposes, as a way of fostering a high-quality provider network that engages in continuous quality improvement for the purpose of sustaining a high-quality service delivery system. Trillium exercises due care when compiling and releasing provider-specific data to the public.

Trillium has established guidelines and standards for sharing this information that protects the providers and public by ensuring that all applicable confidentiality laws and regulations are followed, and limitations of the information are acknowledged and disclosed.

Provider-specific performance data is obtained utilizing information from various data sources, including but not limited to, claims and authorizations in Trillium's software platform. All reports of provider-specific performance data will include a description of the methodology used to develop the report, as well as the uses and limitations of the information.

Trillium may engage in focused clinical and operational improvements with practitioner/provider practices related to performance metrics as a part of alternative payment arrangements in the delivery of care across populations served. This activity could also include training, remediation and technical assistance on value-based purchasing and performance metrics. Trillium's goal is to decrease gaps in treatment and develop improvement opportunities which result in the recruitment and retention of high performing practitioners/providers.

viii. Provider Disaster Plans

Trillium is responsible for providing crisis and emergency services 24 hours a day, 7 days a week. The Trillium Disaster Plan is a comprehensive document designed for use in responding to natural and human-made disasters.

All Trillium contracted providers offering services in a facility must have their own Disaster Plans, including evacuation and fire plans. Depending on the type of disaster, Trillium and certain identified providers could be asked to assist in debriefing of rescue personnel and follow-up crisis counseling with victims. Our contract with providers and the North Carolina Final Rule, requires that you have an adequate disaster plan and training process in place within your organization. Providers are required to submit annually their Disaster Plans including evacuation plans and fire plans.

GG. ABOUT THE MEDICAID WAIVER

i. What is the Behavioral Health I/DD Health Plan?

Trillium is a Prepaid Health Plan (PHP) funded primarily by Medicaid. Trillium operates under the Medicaid 1115 and 1915(c) Waivers. This allows some federal Medicaid requirements to be waived to provide alternatives to the traditional service delivery system.

The Behavioral Health I/DD Health Plan is a combination of two types of waivers authorized by the federal Social Security Act, the federal legislation creating and governing the Medicaid program. They are identified by the specific sections of Social Security Act, which authorizes them.

The Section 1115 Waiver increases provider engagement and support, lowers costs, and improves member experiences and health outcomes for our communities. The Waiver allows States to waive the provisions of the Medicaid program that require "any willing and qualified provider," statewide requirements (meaning Medicaid has to operate the same way in every part of the state), and certain fiscal requirements regarding rate-setting and payment methodologies.

The Section 1915(c) Waiver, generally known as a Home and Community Based Waiver, allows the State to offer home and community-based services not normally covered by the State's Medicaid program if they can be proven to be no more expensive than an institutional level of care covered by Medicaid. In North Carolina this is referred to as the Innovations Waiver.

Both waivers are approved under different federal Medicaid regulations and require different reporting and oversight. This type of waiver system is not intended to limit care but to create an opportunity to work closely with members and providers on better coordination and management of services, resulting in better outcomes for members and more efficient use of resources.

ii. Opportunities the 1115 and 1915(C) Waivers Present

Coordination—These waivers allow us to better coordinate whole person care for members, their families and the providers who serve them for physical, health, I/DD and TBI needs.

Efficient management of fiscal resources—With the transition of all physical, behavioral health, I/DD and TBI services to managed care, the state can better manage all system resources and state budgets.

Flexibility in services offered—We have developed a more complete range of services and supports in the community, including new services, in order to reduce and redirect reliance on high cost institutional and hospital care.

Goals of the 1115 Medicaid Waiver are:

1. To integrate physical and behavioral healthcare.
2. To improve access to care.
3. To improve health outcomes.
4. To promote cost efficiencies.

Through the 1115 Waiver, North Carolina operates different types of health plans:

Standard Plan: serves most members with physical and behavioral health care services.

Tailored Plan: serves members with severe mental illness, substance use disorder, I/DD, and TBI.

Medicaid Direct: serves members who are not enrolled in a Standard Plan or Tailored Plan.

Trillium coordinates services for our members through the Tailored Plan. The Tailored Plan is designed to:

- Administer the 1115 Waiver by providing managed care services to Members with severe mental illness, substance use disorder, I/DD, and TBI.
- Administer two of the State's Medicaid Section 1915(c) Home and Community-Based Services (HCS) Waivers.

- The North Carolina Innovations Waiver for individuals with I/DD and the TBI Waiver for individuals with TBI.
- Offer certain high-intensity behavioral health, I/DD and TBI services to meet the needs of the populations served by these plans.
- Manage the State's non-Medicaid (i.e. State-funded) behavioral health, I/DD, TBI, and substance use services, which are targeted to the uninsured and underinsured North Carolinians.

iii. About the NC Innovations Waiver

The NC Innovations Waiver is a 1915(c) Home and Community Based Waiver. Participation in the Innovations Waiver is limited to the number of individuals approved each year of the Waiver and the funding approved by the North Carolina General Assembly. Under this waiver, members who would otherwise meet the criteria for services in an ICF/IDD setting may receive services in their home and community, as long as the aggregate cost of those services does not exceed the cost of ICF/IDD care.

This waiver incorporates the essential elements of self-direction, Person-Centered Planning, individual budgets, member protections, and quality assurance. The waiver supports the development of a stronger continuum of services enabling members to move to more integrated settings. People served and their families have the information and opportunity to make informed decisions about their health care and services and exercise more control over the decisions they make regarding services and supports.

The NC Innovations Waiver has a Provider-Directed and Individual and Family-Directed track. In the Provider-Directed track, the services are delivered in a traditional manner with staff in the employment of an agency. Members and their families have the option to participate in the Individual and Family-Directed Services or Agency with Choice Model.

Recovery and Resilience

Trillium believes that everyone is resilient and that people can recover from trauma. Everyone deserves to experience a fulfilling and productive life. Through the recovery process, people who experience psychiatric or substance use disorders are empowered to understand that who they are as a whole person—not their diagnosis—is central to their lives. Providers can help their members identify their strengths and reach their goals to achieve recovery through that resilience.

Trillium strives to support members on their path to recovery by engaging in community collaboration and promoting services that improve the health and wellbeing of those we serve. Our hope is that these programs will help individuals achieve their recovery goals and empower them to live in a healthy, safe and meaningful way. This would not be possible without the support and hard work of our providers.

For more information on Trillium's recovery and resilience mission, please read the Member and Recipient Handbooks on our website.

HH. GOVERNANCE & ADMINISTRATION

i. Governance

Trillium is a local political subdivision of the State created under the authority of N.C.G.S. §122C. It is a public authority governed by a 22 member board. The Trillium Board of Directors is a policy-making body, which focuses on establishing and monitoring goals as well as the development of public policy. The Chief Executive Officer reports to the Board, and all other staff of Trillium report to the Chief Executive Officer.

N.C.G.S. §122C-170 requires that area authorities and county programs establish a Consumer and Family Advisory Committee (CFAC). CFAC consists of individuals who receive mental health, intellectual/developmental disability and substance use services and family members of those individuals. It is a self-governing committee that serves as an advisor to Trillium administration and the Board of Directors. Trillium has established five CFACs, one for each region in its catchment area. One CFAC member from each region also serves on the Governing Board.

The duties of the CFAC, as outlined in statute, include:

- Reviewing, commenting on, and monitoring the implementation of the local business plan; identifying service gaps and underserved populations.
- Making recommendations regarding the service array and monitoring the development of additional services.
- Reviewing and commenting on the area authority or county program budget; participate in all quality improvement measures and performance indicators.
- Submitting to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.

Two Tiered Governance Structure

Trillium has a two-tiered governance structure that is made up of Regional Advisory Boards and the Governing Board.

Descriptions of both boards are as follows:

Regional Advisory Boards

- One county commissioner or designee from each county, one other member appointed by the county who fits one of the criteria of G. S. 122C-118.1
- Chair of the Regional Consumer and Family Advisory Committee or appointed designee.
- Duties: Monitor performance at regional level, identify gaps and needs, maintain connection to counties and communities, participate in evaluation of regional directors, appoint members to Governing Board.
- Northern—25 members; Northern Central—23 members, South Central—19 members, Central—19; Southern—19 members, Mid-State—11 members.

Governing Board

- One county commissioner from each Regional Advisory Board
- Chair from each Regional Consumer & Family Advisory Committee
- Two more representatives from each Regional Advisory Board that meet membership requirements
- Provider Network Council Chair or designee (non-voting member)
- **Duties**: all outlined in Statutes including selection and evaluation of CEO, fiduciary responsibility, strategic planning, etc.

ii. Office of the Chief Executive Officer

The CEO is responsible for the overall management of Trillium, including both short and long-term planning. Planning includes the management of resources, direction of the network toward best practices, alignment of incentives with agency planning, how to invest new dollars and how to reinvest savings which occur as service utilization changes.

iii. Executive Management Team

This Executive Management Team strives to maintain strong working relationships with local and state partners including local public agencies, provider agencies, public officials, elected officials, advocacy organizations as well as state and regional staff. Trillium's Executive Management includes management of operations, performance outcomes and achievement of goals, as well as direction of financial resources to achieve desired outcomes. The Executive Management Team directs and supports other Trillium management and staff in achieving agency goals and objectives.

A member of Trillium's executive team leads each of the major functional areas of Trillium:

Business Operations

- Finance
- Claims
- Enrollment and Eligibility
- Human Resources

Clinical Operations

- Care Management
- Care Coordination
- Regional Care Teams
- Transition to Community Living
- Care Management Transitions
- Behavioral Health Care Management
- Innovations
- Call Center & Member Services
- Housing Services
- Neighborhood Connections
- Support Intensity Scale
- Network, Contracts
- Training
- Utilization Management & Transitions of Care

General Counsel

- Compliance
- Appeals
- General Counsel
- Regulatory Affairs

Chief Medical Officer

- Medical Affairs
- Quality Management

Technology and Informatics

- Informatics
- Business Systems
- Information Technology Operations
- Cybersecurity
- Facilities

The Chief Medical Officer is responsible for the oversight of all clinical management of services to members and recipients, including authorization of services, and utilization management. Other activities include collaboration with Trillium network providers, medical providers in the community, and State and community hospitals as well as development of preventive health projects for Trillium members and recipients.

Medicaid Contract Manager

Trillium's Medicaid Contract Manager is the point person for coordination of the Trillium 1115 and 1915(c) Medicaid Waiver.

The Manager is responsible for monitoring the overall performance and compliance of Trillium with all areas of the Medicaid contract and acts as the primary contact with the NC Department of Health and Human Services (DHHS).

iv. Stakeholder & Community Partners

Stakeholder Involvement

Trillium has a comprehensive system of operational forums in order to ensure engagement of members, recipients family members, advocates, providers and community agencies.

This involves a number of operational committees that bring Trillium staff, members, recipients and family members and guardians, providers and stakeholders together to address issues and concerns, to provide important feedback to Trillium around its performance, and to assist in proactive planning.

II. CLINICAL OPERATIONS

Clinical Operations manages Trillium's Call Center and Member Services, Housing, Innovative Development, and Neighborhood Connections. The Clinical Operations Team, operates a call center for service access, oversees the behavioral crisis line, manages housing needs, and coordinates resources for unmet health-related needs.

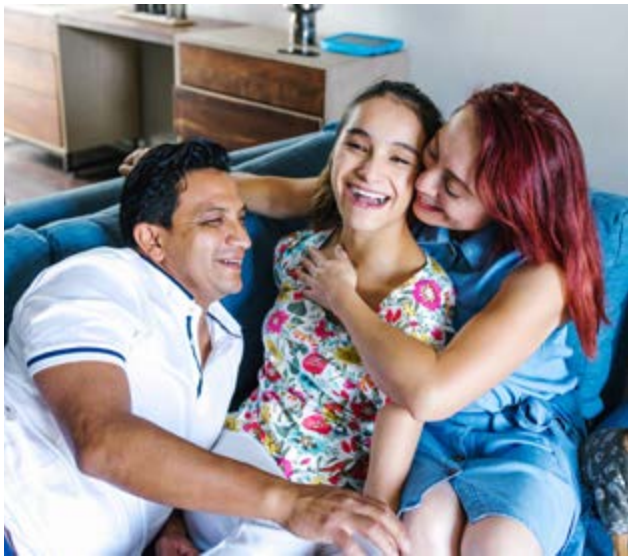
Additionally, it researches utilization trends to use for planning; identifies areas for further study and review; and develops Clinical Guidelines and written protocols.

The Chief Medical Officer oversees all clinical activities performed in Clinical Operations and supports the Clinical Advisory Committee.

i. Trillium Clinical Design Plan

The Trillium Health Resources 1115 and 1915 (c) Waiver are designed to create a system that will more effectively and efficiently address the needs of members and recipients with mental illness, intellectual/developmental disabilities, and substance use disorders.

The successful implementation of this system depends on integration of primary care and behavioral health, as well as coordination and management of all public resources. Federal, State and County funds will be strategically managed for optimal outcomes for people. Trillium has started and continues a thoughtful and transparent process of change and improvement through this implementation.



The complete Trillium Clinical Design Plan is available on the Trillium website (See the Resources & Web Links section at the end of this Manual for the link to this document.)

ii. Call Center, Member & Recipient Services

Trillium is responsible for timely response to the needs of members and recipients and for efficient linkages to network providers. Call Center, Member & Recipient Services staff provides critical monitoring and management of referral follow-up to care, as well as entry of grievances, complaints and concerns.

Member and Recipient Services

Trillium also operates a Member and Recipient Services on Monday through Saturday from 7:00 a.m.– 6:00 p.m. Trillium's Member & Recipient Services enables members and recipients to conveniently access information about benefits or claims, referral assistance and access to treatment or services.

Behavioral Health Crisis Line

Trillium maintains a telecommunications system with 24 hours per day, 7 days per week access to behavioral health crisis services. The Behavioral Health Crisis Line is answered live by a Licensed Clinician. When a member or family member calls the toll free 24-Hour Behavioral Health Crisis Line, staff are able to assess the member's/recipient's needs and offer immediate options for crisis services.

Nurse Line

Trillium provides members and recipients with Nurse Line which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year for medical information and advice on where to access care.

Pharmacy Service Line

Trillium offers a Pharmacy Service Line to assist pharmacies and prescribers with point-of-sale claims questions and pharmacy prior authorizations and clinical coverage criteria, resolve claims payment and adjudication issues, and address general provider questions.

Accessing Routine Services

The Access Standard for Routine Services is to arrange for services within 10 calendar days of contacting the Member and Recipient Services.

Routine Referral Process

1. The Call Center staff will collect demographic information on the caller and search for the member or recipient in the online billing platform.
2. If the member is not located in the eligibility file, the Access Staff will advise the caller of this, and proceed with collection of enrollment data on the most current Trillium Enrollment Form.
3. The Call Center staff will evaluate the member or recipient's clinical need as follows:

- Complete the State-mandated Screening, Triage and Referral tool and document the information obtained following the current online billing platform.
- Retrieve and review the member or recipient's historical information, as needed.
- Use the information provided, determine the type of clinical services needed.

4. The Call Center staff will offer the member or recipient a choice of two (2) providers (when available) and document the selection in the online billing platform. Choice is determined by weighting providers in the following areas:

- Availability of service.
- Proximity to member/recipient.
- Member/recipient's desired attribute in provider or provider specialty.

5. The Call Center staff will call the chosen provider for immediate scheduling with the member/recipient on the line. If an appointment is not available within availability guidelines, the member/recipient may choose another provider.

- Call Center staff will provide the agency with a brief overview of the member/recipient's need for service as well as indicating the service to be provided. Either Call Center staff remain on the line with the provider and member to obtain the date of the initial appointment, or request the provider call back to provide this information.
- This is to ensure appointments are being set within the state required timeframe for the determined level of care and is documented in the computer system.
- In the event the member/recipient chooses to contact the selected agency on his/her own, Call Center staff will indicate this in their documentation.

Trillium network providers are held to the following standard regarding Appointment Wait Time for ROUTINE Referrals: Scheduled—one hour; Walk-in—within two hours.

Accessing Urgent Services

The Access Standard for Urgent Care is to arrange for services within 48 hours of contacting the Member and Recipient Services.

Urgent Referral Process

1. A person's clinical need may be considered URGENT if, but not limited to the following:

- A member/recipient reporting a potential substance-related problem.
- The member/recipient seems at risk for continued deterioration in functioning if not seen within 48 hours.

2. The Call Center staff will collect the enrollment data and proceed with a state screening form to identify treatment needs.

3. After completing the screening, the Call Center staff will offer the member/recipient a choice of two providers (when available) and document the provider selected in the software platform.
4. The Call Center staff will call the chosen provider and schedule an appointment, which must be available within 48 hours, or they will refer the member/recipient to an Open Access provider depending on the member's geographic location. If this does not occur, an explanation is documented.
5. If there are no scheduled appointments available within the required timeframe, or there are no Open Access providers within a reasonable distance of the member/recipient's geographic location, the member will be referred to a walk-in clinic .
6. The Call Center clinician will remind the member that the Trillium Access Call Center is available 24 hours a day and instruct the member to contact the 24-Hour Access to Care Line again by telephone at any time should the situation escalate and require immediate attention. The Call Center will also provide the member with the number for mobile crisis team servicing their county.
7. Trillium Call Center Staff will continue to follow-up with any Urgent contact until it is determined that the member has been able to receive the care that is most appropriate to meet the member/recipient's clinical needs
8. If member/recipient requires urgent care, they are referred to a provider regardless of funding status (Medicaid, Medicare, Insurance, etc.)

Trillium network providers are held to the following standard regarding Appointment Wait Time for URGENT Referrals: Scheduled Appointment—one hour; Walk-in—within two hours.

Accessing Emergent Services

The access standard for Emergency Services is two (2) hours or immediately, for life-threatening emergencies.

In potentially life-threatening situations, the safety and well-being of the member has priority over administrative requirements. Eligibility verification will be deferred until the caller receives appropriate care.

Emergent Referral Process

1. Any calls that are deemed to be EMERGENT are immediately transferred to a Call Center Clinician via a "warm" transfer (Member/recipient remains on the line without being put on hold.) Emergent needs can be life threatening conditions; timeframe for response to emergent needs will be provided by immediate access to care which includes dispatching emergency services by calling 9-1-1.

An EMERGENT situation is indicated if the member demonstrates one or more of the following, including, but not limited to:

- Real and present or potential danger to self or others as indicated by behavior, plan or ideation
- Labile or unstable and demonstrates significant impairment in judgment, impulse control, and/or functioning due to psychotic symptoms, chemical intoxication, or both
- Immediate and severe medical complications concurrent with or as a consequence of psychiatric or substance use illness and its treatment.
- Caller indicates (either by request or through assessed need) a need to be seen immediately
- The Call Center clinician will determine through clinical screening whether the member/recipient represents an immediate danger to self or others. If member is an imminent danger to self or others, the Call Center Clinician will implement crisis intervention procedures by attempting to keep the member/recipient safe until immediate supports or services are in place.
- When possible, the Call Center Clinician will speak to the caller directly until they can be connected to the appropriate level of care.

If Member/Recipient Is Unable to Be Stabilized

1. The Call Center clinician will, with assistance from another staff when needed, contact the appropriate emergency agency (i.e. law enforcement,

emergency medical services, etc.) to respond and attempt to keep the caller on the phone until they arrive. A Call Center agent or coordinator will collect the remaining enrollment data from the crisis worker when it becomes available.

2. Trillium Call Center clinicians will continue to follow-up with any emergency contact until it is determined that the member/recipient has been able to receive the care that is most appropriate to meet the member's clinical needs.

Members and recipients are informed of the availability and types of Crisis Services in the Trillium area through the Trillium Member and Recipient Handbooks, various print materials, Community Collaborative meetings, System of Care coordination efforts, website postings, billboards and local media community bulletin boards.

Trillium network providers are held to the following standard regarding Appointment Wait Time for EMERGENT Referrals: Provider will see all Emergencies within two (2) hours. If situation is life threatening, Provider should seek assistance from the appropriate law enforcement, emergency medical services (EMS) or fire and rescue service.

Process for Service Authorization

1. Clinicians have the ability to authorize initial and concurrent inpatient treatment requests and services such as, but not limited to, Detoxification Services, Facility-Based Crisis Services, Crisis Respite and Mobile Crisis.
2. After reviewing the request, if the member/recipient's situation meets Trillium's established clinical criteria for the requested service, the clinician will complete the following steps:

- Authorize the service based on the Authorization Guidelines.
- If the member's condition does not meet the criteria for the requested service, after the Physician Advisors have made such a determination, the clinician may explore treatment alternatives with the provider and member.

Discharge

Discharge planning begins at the time of the initial assessment and is an integral part of every member's treatment plan regardless of the level of care being delivered.

The discharge planning process includes use of the member/recipient's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the member/recipient with functioning in the community.

The Call Center staff may assist with the discharge planning for members/recipients in acute levels of care.

Among the functions:

- Identify members/recipients who have multiple admissions to acute care facilities and make recommendations, when appropriate, that enhanced services start prior to member discharge.
- Refer the member for Care Management.
- Make follow-up appointments with appropriate community providers.

Follow Up After Discharge

Call Center staff recognize the importance of follow-up care after a member or recipient is discharged from an acute level of care. Every effort is made to ensure the member or recipient is engaged in treatment. All discharge appointments are followed up to make sure the member or recipient was seen. This is done by contacting the provider to verify that the appointment was kept.

If an appointment is not kept, Call Center staff:

- Document the reason, i.e., no show, member or recipient canceled, provider canceled, etc. and whether the appointment was rescheduled.
- If the member or recipient is still not able to engage in treatment, the provider with the assistance of Call Center staff will attempt to re-engage them into services.

JJ. INFORMATION TECHNOLOGY

The Trillium information system must support members, recipients and providers while ensuring confidentiality and privacy. We do this by maintaining a secure software system, email and website.

i. Trillium Website

Our website is a source of information for available services, network providers, provider performance, Tailored Plan events and operations, and links to other websites. The Trillium website is also an essential element in how Trillium and the provider network communicate and conduct business with each other.

ii. Email Communications

E-mail has become the standard method of communication between Trillium and network providers. To make that communication most effective, Trillium uses Constant Contact, a web-based system for maintaining large listservs for information, education and marketing. If you have not received these communications, please subscribe using this form. Visit our Provider Communications page to review the archives of Clinical, Network, and Urgent Notifications.

Providers may send an email to the help desk at NetworkServicesSupport@TrilliumNC.org for any questions regarding paperwork, processes, and other information. The email will be assigned to an agent who will respond in the order your correspondence was received. If you have a question about claims, go to our website to identify your claims representative through the Provider Claims Split document within the Provider Documents section.

CORRESPONDENCE TIMELINES & ADDRESS REFERENCE

ITEM TO BE SUBMITTED IN WRITING TO TAILORED PLAN	TIMEFRAME FOR SUBMISSION	ADDRESS TO SUBMIT
Review/fully executed contract	*within 30 business days of receipt of contract of such*	Trillium Health Resources Attn: Network Development Staff 201 West First St. Greenville, NC 27858-1132
Provider Appeals	*within 30 days from date of receipt of the letter*	Address to Submit: Trillium Health Resources Attn: Appeals Department 201 West First Street Greenville, NC 27858-1132
Changes in Current Practice Information—Provider Change Form	*within one (1) business day of any changes in status* *within five (5) business days of personnel changes or information updates*	Follow the instructions on the bottom of the Provider Change Form or NetworkMonitoring@TrilliumNC.org
Plan of Correction (POC) *Revised POC Resubmission*	*within 15 calendar days of delivery or attempted delivery of the POC request letter* *10 calendar days to revise the POC*	E-mail to the Trillium staff member who requested the POC
Additional Respite Site Application	*As needed*	NetworkMonitoring@TrilliumNC.org
Medicaid Services Appeal-Level I (on behalf of member with written permission from member/ parent/guardian)	*within 60 days of the date of the Notice of Adverse Benefit Determination*	201 West First Street Greenville, NC 27858-1132 Fax: **(252) 215-6879** Upon receipt of fax confirmation page, please contact Trillium Appeals Department to confirm receipt of said fax at **1-877-685-2415**.

RESOURCES & WEB LINKS

Trillium Resources

- Benefit Plans & Service Definitions
- Billing Codes & Rates & Checkwrite Schedule
- Claims Request Form
- Cultural and Linguistic Competency Action Plan Recommendations
- Provider Direct
- Provider Learning Campus User Agreement
- Provider Documents & Forms
- Records Retention Log
- Electronic Visit Verification

Trillium Provider Communications

- Clinical Communication Bulletins
- Network Communication Bulletins
- Sign up fpr Email Lists

NC DHHS Resources

- NC-TOPPS Guidelines
- Clinical Coverage Policies, Division of Medical Assistance
- NC-SNAP Guidelines
- Prior Approval and Due Process Procedures
- Classification of Incidents (Level I, II, or III)
- Plan of Correction Template
- Service Definitions
- Behavorial Health Services
- NC Innovations Waiver
- NCDHHS Division of Health Benefits

Fraud, Waste, and Abuse/Program Integrity List

- OCPI/Fraud, Waste, and Abuse
- EthicsPoint

Limited English Proficiency (LEP)

- Federal agency: Limited English Proficiency
- NC Interpreters and Transliterates Board
- Sign Language Interpreters/Transliterates Directory
- Carolina Association of Translators and Interpreters

Legal Documents

- Psychiatric Advanced Directive (PAD) and Health Care Power of Attorney Legal Forms

IMPORTANT EMAIL ADDRESSES

NetworkMonitoring@TrilliumNC.org

Is used for provider monitoring reviews, provider change forms.

TrilliumProviderDirectory@TrilliumNC.org

Is used to submit questions related to Trillium's Provider Directory.

NetworkManagement@TrilliumNC.org

Is used for questions regarding Network Communication bulletins and submission of reports for Non UCR contracts (CURES reports, etc.).

NetworkServicesSupport@TrilliumNC.org

Is used for any other questions providers may have, enrollment/credentialing, statements around voluntarily withdrawing from the network.

UM@TrilliumNC.org

Is used to request UM criteria decision-making guidelines, or call the Provider Support Service Line at **1-855-250-1539** to request a hard copy.

Trillium submits this Provider Manual to Department for approval thirty (30) days after Contract Award and will not use or distribute prior to approval by Department. Trillium regularly reviews and updates this Provider Manual annually, with submission due on July 1st, or upon request by the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or Trillium policies, procedures, bulletins, guidelines or manuals, or Trillium business processes as necessary. Within the provider manual, Trillium shall track and maintain a list of revisions made to manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed. Trillium may update this Provider Manual once per quarter in the event of substantive updates or revisions that impact providers or BH I/DD Tailored Plan/PIHP business. Unless directed by the Department, Trillium shall not update the provider manual more than once per quarter during the Contract Year. Submissions of the provider manual to the Department by Trillium during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section. Trillium will submit this Provider Manual to Department for approval within fifteen (15) calendar days of making substantive updates or revisions. Trillium will make the redline Provider Manual available, within five (5) calendar days of approval from the Department, in an electronic version accessible via website or the provider web portal, and in writing upon request of a contracted provider. Trillium will not post, print or enforce the updates until Trillium has received approval from the Department. Trillium will correct errors in the electronic version of this Provider Manual or make revisions as requested by the Department within fifteen (15) calendar days of notification or request by Department. Corrections or revisions to the printed version will be included in the next printing.

Transforming Lives. Building Community Well-Being.