TRILLIUM HEALTH RESOURCES

MEMBER AND RECIPIENT HANDBOOK

YOUR BENEFITS

FOR SEVERE MENTAL HEALTH, SUBSTANCE ABUSE & INTELLECTUAL/DEVELOPMENTAL DISABILITY SERVICES

APRIL 2022

www.TrilliumHealthResouces.org

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

ABOUT THIS HANDBOOK

This handbook is available in Spanish and in alternate formats (braille, large-print, audio). If you need an alternate version or have limited reading ability, call Member and Recipient Service at 1-877-685-2415.

Este manual está disponible en español y en formatos alternativos (braille, letra grande, audio). Si necesito infomación en español, o una versión alternativo, o tienen una limitida, llámenos al 1-877-685-2415.

We are designated by the NC Department of Health & Human Services to oversee state and federally funded services for 28 counties in eastern North Carolina.

Trillium is responsible for providing access to and oversight of services for individuals who receive Medicaid or state funding for their care. Trillium complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, sexual orientation or gender identity.

Trillium requires priority admission to all women who are pregnant and injecting drugs, pregnant and using substances, and other individuals who are injecting drugs.

Trillium does not publish materials or share information that is intimidating, misleading, or inaccurate.

Member & Recipient Service Line:
1-877-685-2415

Please note the toll-free Member and Recipient Service Line, 1-877-685-2415, is intended for and limited to members/recipients and issues around their care.

Please visit our website to add your mobile phone number and/or email address to receive informational texts or emails from Trillium.

Administrative & Business Line:
1-866-998-2597

Please use the Administrative and Business Line for complaints, grievances, and when instructed in this handbook.

IF YOU ARE EXPERIENCING A MEDICAL EMERGENCY DIAL 9-1-1

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FULL

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

WELCOME!

If you are Medicaid eligible, do not have insurance or are underinsured, and your benefits are established in one of the 28 counties we serve, you could be eligible for the plan administered by Trillium Health Resources.

Trillium Health Resources is a Local Management Entity/Managed Care Organization (LME/MCO).

TRILLIUM REGIONAL OFFICES

Northern Regional Office

144 Community College Rd.
Ahoskie, NC 27910

Central Regional Office

201 West First St.
Greenville, NC 27858

Southern Regional Office

3809 Shipyard Blvd.
Wilmington, NC 28403

COUNTIES SERVED BY TRILLIUM HEALTH RESOURCES

Services described in this handbook are available to qualified residents of these NC counties:

Northern

- Bertie
- Camden
- Chowan
- Currituck
- Gates
- Halifax
- Hertford
- Martin
- Northampton
- Pasquotank
- Perquimans

Central

- Beaufort
- Craven
- Dare
- Hyde
- Nash
- Pamlico
- Pitt
- Tyrrell
- Washington

Southern

- Bladen
- Brunswick
- Columbus
- Carteret
- Jones
- New Hanover
- Onslow
- Pender

MY PERSONAL HEALTHCARE CONTACTS

Use the following boxes to write the names of the people working with you for your mental health, substance use, or I/DD services.

My behavioral healthcare Provider's name	
My behavioral healthcare Provider's phone number	
My primary care physician's name and phone number	
My Pharmacy	
Trillium's Member and Recipient Service Line (Toll-free)	1-877-685-2415
Mobile Crisis Services Number for my county	
The name of the closest hospital for medical needs	
The phone number of the closest hospital for medical needs	

Use the following boxes to write the names of any physical or other health care providers.

Keep this handbook where you can easily find it for future reference.

A MESSAGE FROM OUR CEO

Welcome to Trillium Health Resources!

Trillium Health Resources manages mental health care for individuals with severe mental illness, substance use, intellectual/developmental disabilities, and traumatic brain injury in 28 counties in eastern North Carolina.

We cover Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, and Washington Counties. If you live in these counties and need the services we manage, this handbook provides information to help you get the care you or your family needs.

Trillium manages public funds to serve the people within our service area. We do this by working with providers to deliver services. We also make sure the services you or your family receive meet your needs. We have high standards for providers in our network. We work very hard to make sure our providers meet these standards.

I hope you find our system easy to use and that you are pleased with the services you receive. We welcome your feedback, both good and bad. Knowing about problems helps us make improvements. Hearing about good experiences gives us important information about provider performance. We encourage you to call us at 1-866-998-2597 to share your thoughts, or you can visit our website to complete a "Complaint, Grievance, Compliment or Question" submission form.

We are honored to serve you.

Joy Futrell
Chief Executive Officer

WELCOME TO TRILLIUM HEALTH RESOURCES

In this section:

- Welcome to Trillium!
- Who is Trillium?
- How is Trillium governed?
- How can I get involved?
- What is Trillium's position on discrimination?
- What is EthicsPoint?

WELCOME TO TRILLIUM HEALTH RESOURCES!

Trillium is a government agency that manages Medicaid, block grant, state and local funding for severe mental health, intellectual and/or developmental disabilities (I/DD) and substance use disorder, and traumatic brain injury (TBI) services. We manage services in Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell and Washington counties. Our mission is to transform lives and build community well-being through partnership and proven solutions.

WHO IS TRILLIUM?

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 provides:

- Access to a variety of services to meet your individual needs
- Call center staff to assist with questions or refer to care
- Clinical reviews to make sure your care is medically necessary and best meets your needs
- A network of healthcare providers
- Management of the network of providers to make sure that quality services are available locally
- Receipt and resolution of all concerns, grievances and requests for appeals in a timely manner
- Community education programs and trainings
- Access to care for individuals leaving hospitals, jails, state residential facilities and treatment centers

Trillium is responsible for efficiently managing the limited public resources available for our services. We believe it is important to work in partnership with individuals, families and community stakeholders, like Departments of Social Services, Health Departments, Department of Juvenile Justice, Federally Qualified Health Centers and local hospitals, to meet the needs of people in our region. Trillium is committed to caring and working to improve well-being in our communities to help develop the sturdy foundation needed to prevent problems later.

Members of our provider network must undergo a rigorous credentialing review and are continuously monitored to ensure quality. We are nationally accredited in the areas of Health Call Center, Health Network and Health Utilization Management, and as a Managed Behavioral Healthcare Organization. Trillium is a Medicaid managed care organization. The N.C. Department of Health and Human Services (DHHS) contracts with us to operate the N.C. Medicaid combined 1915(b)/(c) Waiver in our region, also known as our catchment area.

For more information about Trillium, visit www.TrilliumHealthResources.org or call our toll-free, free Member and Recipient Service Line at 1-877-685-2415. You can ask questions, receive information, file grievances, or request a printed copy of our Member and Recipient Handbook.

You may access a list of providers on the Trillium website at www.TrilliumHealthResources.org by clicking "Find a Provider" at the top of the screen. You can look for providers by location, clinical focus, and specialties. The provider listing will include their name, addresses, telephone numbers, if they are accepting new members, any non-English languages spoken by staff and qualifications. Upon request, Trillium will provide you with more information on your provider. You can also call 1-866-998-2597 to request a printed copy of providers to be mailed to you.

HOW IS TRILLIUM GOVERNED?

Trillium is governed by a Governing Board of Directors that includes three county commissioners; individuals with specific healthcare, social services, insurance, hospital administration and mental health expertise; and three members of the Trillium Consumer and Family Advisory Committee (CFAC).

Trillium has a two-tiered governance structure to keep its administration close to the communities we serve. The first governance level is made up of three Regional Advisory Boards. In turn, these Advisory Boards elect representatives to make up the Trillium Governing Board, our top level of governance.

HOW CAN I GET INVOLVED?

To get up to date information from Trillium about programs and events, please visit our website to add your mobile phone number and/or email address to receive informational texts or emails from Trillium.

As a member of Trillium, you can participate in our CFAC (Consumer and Family Advisory Committee). The CFAC includes people who receive or have received MH/ I/DD/SUD services and their relatives or guardians. The CFAC is a self-governing advisory committee that operates under its own bylaws.

Three CFAC members also serve as voting members on our Governing Board. Under state law, the CFAC has the following certain responsibilities:

- Review, comment on and monitor implementation of the local business plan
- Identify service gaps and underserved populations and make recommendations about needed services
- Review and comment on our annual budget
- Participate in quality improvement activities
- Submit recommendations to the state CFAC about ways to improve service delivery
- The CFAC helps ensure that people receiving services are involved in our oversight, planning and operational committees.

If you are interested in becoming a CFAC member or want to learn more about the Trillium CFAC, call 1-866-998-2597 or visit www.TrilliumHealthResources.org and select "Regional Operations."

We also have a Human Rights Committee (HRC) that protects the rights of people receiving services. The HRC is responsible for reviewing complaints about violations of member rights, including privacy concerns. Most of the people on this committee either receive services or are a family member of someone who receives services. The HRC reviews potential rights violations and monitors trends in the use of restrictive interventions, abuse, neglect and exploitation, deaths and medication errors. The committee provides valuable feedback on potential improvements and overall trends.

Your provider may also have a Human Rights Committee. You may call your provider for more information or contact Trillium at 1-866-998-2597 for more information. If you are interested in serving on the Human Rights Committee, you must be an adult member, family member, human service professional, or a Trillium Network Provider, and live in one of the counties in our catchment area. You can fill out a Human Rights Committee Application Form to be considered for membership, or if you have any questions call Trillium at 1-866-998-2597.

WHAT IS TRILLIUM'S POSITION ON DISCRIMINATION?

Trillium complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex, sexual orientation or gender identity. We do not stand for racism, in all its forms. We do not stand for exclusion, whether against people of different abilities or different races. We do not stand for limiting anyone's potential, through restrictive practices or beliefs. Trillium and its contracted providers also do not discriminate based on ethnicity, religion, creed, gender identity, sexual orientation, marital status, family/parental status, genetic information, income derived from a public assistance program, political beliefs or any other category protected under federal or state law.

Trillium provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large-print, audio, accessible electronic formats and other formats)

Trillium also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Trillium at 1-877-685-2415.

If you believe that Trillium Health Resources has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Trillium Health Resources
201 West First St.
Greenville, NC 27858
By phone 1-866-998-2597
By fax 1-252-215-6879
TTY Dial 711 or 1-800-735-2962
Email info@trilliumnc.org**.**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Trillium's call center agents are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html

ATTENTION: Trillium does not publish materials or share information that is intimidating, misleading, or inaccurate. If you do not speak English, language assistance services are available to you, free of charge. Call 1-877-685-2415 (TTY: 1-800-735-2962).

WHAT IS ETHICSPOINT?

EthicsPoint is a secure and confidential (private) tool to report suspected fraud, waste and abuse. EthicsPoint can be accessed **24 hours** a day, **7 days** a week.

You can contact the Trillium Human Rights Committee or file a grievance by calling 1-866-998-2597 You can also report anonymously by calling Trillium's EthicsPoint toll-free hotline at 1-855-659-7660. Or, you may submit a report online by visiting www.TrilliumHealthResources.org and clicking Report Fraud and Abuse on the bottom of the page.

If you prefer to contact someone other than Trillium, please call the N.C. DHHS Customer Service Center at 1-800-662-7030. This number is monitored by an external, third-party vendor, and your call will be completely anonymous if you choose.

WHAT IS THE MEDICAID WAIVER?

In this section:

- What is the Medicaid Waiver?
- What is the NC MH/IDD/SAS Health Plan?
- What is the 1915(c) Innovations Waiver?
- What is the Registry of Unmet Needs?
- How do I know if I am eligible for services under the Trillium Health Plan?
- What if I have insurance other than Medicaid?
- What if I am moved from Trillium to the Standard Plan?
- What if I do not feel I need to be on Trillium's Plan?
- What if I am a member of a Federally-Recognized Tribe?

WHAT IS THE MEDICAID WAIVER?

Trillium operates under Medicaid 1915(b)(c) Waivers. This allows some federal Medicaid requirements to be waived to provide alternatives to the traditional service delivery system. If you receive Medicaid from any of the counties in the Trillium area and have need of the services we cover, you are a member of the Trillium Medicaid 1915(b)(c) Waiver.

Goals of the Medicaid Waiver are:

1. To improve access to care.
2. To improve health outcomes.
3. To promote cost efficiencies

Benefits of the 1915 Waiver are that:

- You have choice of provider within the Trillium network.
- Medically necessary needs are met.
- There is a process for grievance resolution.
- You have the opportunity to get second opinions.

Requirements for Trillium under the Medicaid Waiver are to:

- Provide telephone contact 24 hours a day, 7 days a week
- Provide emergency referrals 24 hours a day 7 days a week, within two hours of the request for services
- Provide urgent care within 48 hours of the request for services
- Provide routine care within 10 calendars days of the request for services
- Have qualified staff to evaluate services requested by providers
- Offer a qualified provider network with choice of at least two providers where available, except for crisis services and other specialized services
- Provide written material explaining the benefit plan, how to access services and member rights

North Carolina's 1915 (b)(c) Medicaid Waiver is approved by the federal Centers for Medicare & Medicaid Services (CMS).The Waiver is a managed care/freedom of choice waiver that covers Medicaid beneficiaries in our catchment area for severe mental health, intellectual/developmental disabilities (I/DD), substance use, and traumatic brain injury (TBI) services.

It is called a "waiver" because some requirements of the federal Social Security Act are waived:

- Waives state-wideness: Allows North Carolina to have behavioral health managed care plans in specific areas of the state, such as our 27-county region
- Waives comparability of services: Lets North Carolina provide different benefits to people enrolled in the managed care system
- Waives freedom of choice: Allows Trillium to have a closed network and require Health Plan members to choose from providers within that network, with some exceptions

The 1115 Waiver launches in North Carolina in July 2021 with the Standard Plans. These plans will serve most members with physical and basic behavioral health needs. Managed care organizations such as Trillium will continue to serve members with severe mental health and substance use needs, along with I/DD and TBI.

The N.C. MH/IDD/SAS Health Plan is designed to:

- Better coordinate the system of care for individuals, families and providers
- Manage resources better so that service dollars can be directed to those most in need
- Develop a more complete range of services and supports in the community so that more people can receive services in their community, with as little disruption to their lives as possible
- Create new, optional (b)(3) services funded with savings Trillium achieves by managing care more effectively. These (b)(3) services are only available for people with Medicaid and are identified by reviewing what kind of practices work best and listening to feedback from members and families

Trillium ensures there is an array of services and providers in the counties served. Individuals ages 3 years and older with Medicaid coverage from one of our counties are eligible to receive mental health, substance use and intellectual/developmental disability (I/DD) services. The services available include those covered by the current North Carolina Medicaid Plan. The 1915(b) Waiver allows services to be added that may not be included in the current North Carolina Medicaid service options. The addition of any new services will be based on best practices. New services added will involve input from members and families.

Trillium's provider network is developed to make sure evidence-based practice services are available. Evidence-based services integrate research, clinical expertise and patient value into the decision-making process for member care. You can choose from any provider in Trillium's network who is eligible to provide the approved service. You will receive information and education to help choose providers by calling the Member and Recipient Service Line at 1-877-685-2415.

WHAT IS THE NC MH/IDD/SAS HEALTH PLAN?

Trillium ensures the availability of a variety of services and providers in the counties it serves. Individuals **three (3) years** of age or older with Medicaid coverage in one of our service counties are eligible for mental health, intellectual and/or developmental disability (I/DD), and substance abuse services. Available services include those currently covered by the North Carolina Medicaid plan. The 1915(b) exemption allows the addition of services that may not be included in current North Carolina Medicaid service options. The addition of any new services will be based on best practices. New services added will include contributions from members and their families.

Trillium's provider network is developed to ensure the availability of evidence-based practice services. Evidence-based services integrate research, clinical experience, and patient worth into the decision-making process for member care. You can choose any provider within the Trillium network who is eligible to offer the approved service. You will receive information and instructions to help you choose providers by calling the Member and Recipient Service number at 1-877-685-2415.

The NC MH/IDD/SAS Health Plan description of services and clinical policies are available at the N.C. Division of Health Benefits Clinical Policy 8P.

For more information about the Health Plan, please call the Member and Recipient Service number at 1-877-685-2415, or read the Trillium's NC Innovations Individual and Family Guide.

WHAT IS THE 1915(C) INNOVATIONS WAIVER?

The Innovations Waiver is a home and community-based services waiver for people with intellectual and/or developmental disabilities (I/DD). Trillium manages this Waiver in our 28 counties. The Innovations Waiver serves individuals of any age and allows long-term care services to be provided in home and community-based settings for people with an I/DD who meet institutional level of care criteria. Participation in the Innovations Waiver is limited to the number of individuals approved by the federal Centers for Medicare & Medicaid Services (CMS) each year of the Waiver and the funding approved by the N.C. General Assembly.

The Innovations Waiver offers individuals and families two levels of control and responsibility:

1. Provider Directed Services
2. Individual and family-directed supports options (which includes the Agency with Choice and Employer of Record models). Under this option, individuals or families have greater control of all or part of the supports in their Individual Support Plan

The Innovation Waiver description of services and clinical policies are listed in the N.C. Division of Health Benefits Clinical Policy 8P.For more information, please refer to Trillium's NC Innovations Individual and Family Guide.

WHAT IS THE REGISTRY OF UNMET NEEDS?

The Registry of Unmet Needs (RUN) is a list maintained by Trillium to keep track of people waiting for I/DD services. To learn more about the Innovations Waiver or the Registry of Unmet Needs, call Trillium's Member and Recipient Service Line at 1-877-685-2415. Trillium staff will review the request and determine if there are other options in the service array that could meet the member's needs before adding them to the Registry of Unmet Needs. We strongly encourage parents/guardians of members who have an I/DD diagnosis and may need Innovations services to call us so that you can add them to the registry now.

HOW DO I KNOW IF I AM ELIGIBLE FOR SERVICES UNDER THE TRILLIUM HEALTH PLAN?

The Trillium Health Plan is for individuals who are already on Medicaid. To be eligible for Medicaid coverage in the Trillium region you must:

- Be a U.S. citizen or provide proof of eligible immigration status
- Be a resident of North Carolina
- Have a Social Security number or have applied for one
- Apply and be approved for Medicaid at your local Department of Social Services (DSS) office
- Be in one of the Medicaid aid categories that qualifies you under the Trillium Health Plan

If you are currently receiving Supplemental Security Income (SSI), Special Assistance to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled, you are automatically eligible for Medicaid and do not have to apply at DSS.

Trillium does not allow co-payments, deductibles or other forms of cost-sharing for Medicaid members for mental health, I/DD, substance use, or TBI services per the contract with the N.C. Department of Health Benefits. In addition, members are not required to pay for missed appointments. Some services are available for those who do not have Medicaid, or are uninsured or underinsured; please see page 19 for a list of services available.

WHAT IF I HAVE INSURANCE OTHER THAN MEDICAID?

You should tell both Trillium and your provider if you have insurance other than Medicaid. This could include Medicare or private insurance. Federal regulations require Medicaid to be the "payor of last resort." Medicaid pays for services after your other insurance (including Medicare) has processed the claim and made a payment determination.

WHAT IF I AM MOVED FROM TRILLIUM TO THE STANDARD PLAN?

Trillium works with NC DHHS to determine when members may no longer need the more extensive services available under Trillium. When this occurs, members are transferred to the Standard Plan. The Standard Plan serves most individuals receiving Medicaid services in North Carolina with physical health care and some of the behavioral health services available with managed care organizations such as Trillium.

There are still many services available in the Standard Plan for mental health and substance use disorders, including:

- Individual and group therapy
- Facility-based crisis programs
- Mobile crisis management services
- Outpatient opioid treatment
- Alcohol and drug use treatment center detox crisis stabilization

NC DHHS will notify you when you will be transferred to the Standard Plan. You will be able to work with the Enrollment Broker who will guide you in selecting one of the health plans available. You can call the Enrollment Broker at 1-833-870-5500.

The Enrollment Broker will help you in:

- Search for a provider
- Getting your clinical information and transferring medical records (i.e. care plans or other supporting documentation)
- Answering any other questions

Members can also choose to "opt out" of" Trillium and receive services on the Standard Plan, instead. Please see next section "What if I do not feel I need to be on Trillium's Plan?" You should be able to remain with the same primary care provider and any specialists you have seen once you transition to the Standard Plan, but the Enrollment Broker will be able to answer specific questions you have regarding this process.

WHAT IF I DO NOT FEEL I NEED TO BE ON TRILLIUM'S PLAN?

If you think your mental health or substance use conditions are not severe enough to require the services through Trillium, you can opt out and choose to transfer to the Standard Plan. Please discuss this choice with your care team (primary care provider, counselors, and others) before making a final decision. While you may be experiencing a temporary improvement in symptoms, your providers will help determine if your treatment could be negatively affected by such a transition. Members should be aware that the Standard Plans do not cover benefits or services for individuals with I/DD or TBI. Members can call the Enrollment Broker at 1-833-870-5500 if they want to move to the Standard Plan.

WHAT IF I AM A MEMBER OF A FEDERALLY-RECOGNIZED TRIBE?

Federally recognized tribes have the option to enroll in separate plans called the Tribal Option. This plan addresses the unique cultural, physical/medical behavioral, and social determinants of health needs of federally recognized tribal members and other individuals eligible to receive Indian Health Services. Currently the only federally recognized tribe in North Carolina is the Eastern Band of Cherokee Indians (EBCI).

EBCI members and other individuals eligible to receive Indian Health Services will be enrolled in the Tribal Option if they live in the five western counties of Swain, Jackson, Haywood, Cherokee, and Graham counties. Individuals will have the ability to opt out of the Tribal Option if they reside in those five counties and participate in Medicaid Managed Care (either a Standard Plan or an MCO) or NC Medicaid Direct. If you would like to opt out of Trillium and choose the EBCI instead, please call the Enrollment Broker at 1-833-870-5500.

HOW DO I ACCESS CARE?

In this section:

- How do I access care?
- When should I call Trillium?
- What if I am hearing-impaired?
- How can I get assistance in languages other than English, or if I'm Blind?
- What happens when I call Trillium?
- How are my needs assessed?
- How are emergency situations handled?
- Can I get help with transportation to appointments?

HOW DO I ACCESS CARE?

Trillium will help you access services. However, you can access services directly from any provider in the Trillium network. You can go directly to a provider of your choice. They will help you get enrolled in services. You do not need to call Trillium first. You may schedule your appointment directly with the provider or walk into their office.

You may call Trillium Health Resources toll-free at 1-877-685-2415 to access services. The staff who answers is able to help you with the following:

- Enroll in the mental health, intellectual/ developmental disability, and substance use system
- Complete a brief telephone screening to determine urgency
- Schedule an appointment for an assessment with a network provider
- Provide information on community resources
- Arrange for face-to-face crisis intervention services
- Access Peer Support services

Important: If you have a medical or life-threatening emergency, **call 911** or **go to a hospital emergency department**. You do not need to call Trillium first. A life-threatening emergency is when you or another responsible person thinks you need care immediately so that you or someone else does not get hurt. If you have Medicaid, you will not be responsible for payment of services in the event of an emergency. You also do not have to go to a provider or facility in the Trillium network for emergency treatment.

WHEN SHOULD I CALL TRILLIUM?

You should call Trillium if you:

- Worry about an emotional, learning or behavioral problem
- Worry about a drug or alcohol problem
- Need a provider or want to change providers
- Are having trouble finding a provider to meet your needs
- Feel afraid of thoughts, mood or emotions.
- Feel depressed or anxious or are experiencing prolonged sadness, sleeping more or unable to concentrate
- Are looking for behavioral health services for your child
- Are a parent or guardian of a child who has been diagnosed with an I/DD and need services/ supports to help you meet the needs of your child
- Believe your child has excessive complaints of physical ailments, cannot cope with daily problems or has sudden changes in sleeping or eating habits
- Have recurring thoughts of death or suicide and/ or engaging in self-harming behaviors
- Feel like each day is worse than the day before or no longer take pleasure in former interests
- Have a trusted person, like a friend, family member, teacher, counselor or doctor, who thinks that you need help
- Want information about Trillium's Health Plan benefits
- Have questions about changes in the Waiver, your benefits or services
- Want to file a complaint or grievance, or you need help filing an appeal
- Need to be connected to your assigned care manager or another Trillium staff person
- Would like more information about mental health, I/DD or substance use resources

Trillium can connect you to a provider that will meet your needs. You will be offered a choice of appropriate providers. You can choose the one you think will best meet your needs. Trillium will schedule an appointment with the provider you choose.

WHAT IF I AM HEARING-IMPAIRED?

If you are deaf or hard-of-hearing and have a TTY device, please follow these steps to contact the toll-free Trillium Member and Recipient Service Line through relay communications:

1. **Dial 711** or **1-800-735-2962**
2. When the message "RC NBR Calling PLS GA" appears on the TTY display screen, type "1-877-685-2415" for the toll-free Trillium Member and Recipient Service Line.
3. A Relay Communications Assistant will answer, place your call and assist you throughout the call.

Trillium works with agencies that specifically serve persons who are deaf or hard of hearing. For more information about these agencies, contact us through the Member and Recipient Service Line at 1-877-685-2415.

HOW CAN I GET ASSISTANCE IN LANGUAGES OTHER THAN ENGLISH, OR IF I'M BLIND?

Trillium staff can connect you to an interpretation service for languages other than English. This is a free service to you, and available on any call. You may have to wait briefly for the conference call with the interpreter to begin. Free interpretive service is available when working with Trillium providers as well.

Trillium can also translate this member handbook, forms, and brochures into other languages in addition to English and Spanish, including Braille. Please call the Member and Recipient Service Line at 1-877-685-2415 to request translation of materials into other languages.

Trillium también puede traducir este manual, formularios y folletos en otros idiomas además de Español. Por favor llame la Línea de Servicios para Afiliados y Beneficiarios 1-877-685-2415 para solicitar traducciones de materiales impresos en otro idioma de su preferencia.

WHAT HAPPENS WHEN I CALL TRILLIUM?

A trained Trillium professional will listen to you and ask you questions. We have licensed clinicians available when necessary to assist you. Please be as clear as possible in explaining your needs. If you already have a provider, we will try to contact members of your treatment team. If you don't have a treating provider, that's okay. We will help you make an appointment for an evaluation. First, we will make a referral for help according to our assessment of your needs and the severity of the problem.

We want to help link you to the best services for your needs. Many times, we will be able to connect you with the right provider the first time you call. When referring callers for services, we will try to offer provider choices that best match your requests and needs. Once you choose a provider, we will call the provider you select and make an appointment for you while you stay on the line.

HOW ARE MY NEEDS ASSESSED?

People with the same diagnosis can have very different strengths and abilities. Using nationally recognized assessment tools, Trillium will evaluate your level of functioning. Assessment tools are a standardized set of guidelines used by clinicians to perform the initial assessment of your needs. This assessment will be shared with the provider before your appointment. This information sharing will prevent duplicate services and will allow services to begin in a timely manner. That means you can start receiving services and supports sooner.

Trillium will triage (assign a level of urgency) your needs into one of three categories: emergent, urgent or routine. What you share with Trillium will determine under which category your needs fall.

Mobile crisis services are available in all counties that Trillium serves. For more information about alternatives to hospital emergency departments, please see **Section 4** of this handbook. For urgent and routine needs, we will help you set up an appointment.

HOW ARE EMERGENCY SITUATIONS HANDLED?

If you have a life-threatening emergency, call 911. You may also go to the nearest emergency department. You do not need to call Trillium before calling 911 or before going to the emergency department. Emergency care does not require prior approval or authorization from Trillium. We do not define what an emergency is. In an emergency, you should speak with your service provider as soon as possible. Your provider can listen to your concerns and help you receive the emergency care you need.

Mental health emergencies are serious but do not always require a visit to the emergency department. Most mental health emergencies can be handled by calling your provider. Crisis services are covered in more detail in section 4. Providers will also assist with post-stabilization services (offered after the emergency situation occurs). Post-stabilization services do not require pre-authorization, and we help ensure services are provided. Providers offering post-stabilization services will vary based on member's location and direct needs and may differ from where member received emergency or crisis services.

CAN I GET HELP WITH TRANSPORTATION TO APPOINTMENTS?

If you receive Medicaid, you can use non-emergency medical transportation (NEMT) for trips to and from the doctor's office, the hospital or another medical office for Medicaid-approved care. This is offered through your local Department of Social Services (DSS). This service is available in counties Trillium serves. Contact your local DSS office to find out how to use this service. You can also call Trillium at 1-877-685-2415 for help in contacting your local DSS office. You can request that the initial appointment be in your home if transportation is an issue. You and your provider can make a plan for transportation to future appointments.

CATEGORIES OF NEED		
If you have an EMERGENT NEED (2 HOURS)	***If you have an URGENT NEED (48 HOURS)***	***If you have a ROUTINE NEED (10 DAYS)***
This means you: • Are suicidal • Are homicidal • Are at risk of harm without supervision • Are actively psychotic (bizarre thought processes) with impaired self-care • Report hallucinations and delusions that may result in self-harm or harm to others • Are severely incapacitated • Are experiencing significant distress related to substance use (tremors, sweats, etc.)	*This means you:* • Are not actively suicidal or homicidal (deny having a plan) • Report significant depression or anxiety but no plan for harm • Display mild to moderate symptoms • Recently experienced hallucinations or delusions but none currently • Could rapidly worsen or progress to emergent need without immediate intervention	*This means you:* • Report no risk of harm to self or others • Can care for yourself on a daily basis • Are experiencing distress that is not incapacitating
What will happen? We will arrange face-to-face care from an emergency services provider after the request for emergent care is started, or immediately for life-threatening emergencies. Members who present with Emergent needs will be provided IMMEDIATE access to care which includes dispatching emergency services by calling 911.	*What will happen?* We will make an appointment for you to receive a face-to-face service assessment and/or treatment from a Trillium network provider within 48 hours of the request for care.	*What will happen?* We will make an appointment for you to receive face-to-face care for service assessment and/or treatment within 10 calendar days of the request for care.

HOW DO I GET HELP IN A CRISIS?

In this section:

- How do I get help in a crisis?
- What is a behavioral health crisis?
- Should I call my provider if I am in crisis?
- What are mobile crisis teams?
- How do I access mobile crisis services?

HOW DO I GET HELP IN A CRISIS?

In a crisis, you should seek help, especially if you feel concerned about your safety or the safety of someone you know. The phone number you call first will depend on the type of crisis or emergency and when it happens. **If you have a life-threatening emergency, call 911.** You may also go to the nearest emergency department. You do not need to call Trillium before calling 911 or before going to the emergency department. Emergency care does not require prior approval or authorization from Trillium. Trillium does not define what an emergency is. This may include situations where a person has caused severe physical harm to himself/herself or others. If you are experiencing a crisis that is not life threatening, you should directly call the mobile crisis team serving your county **(page 36)**.

WHAT IS A BEHAVIORAL HEALTH CRISIS?

A behavioral health crisis exists when a person shows symptoms of severe mental illness or substance use disorder, such as:

- Suicidal, homicidal or other violent thoughts or actions
- Psychosis: partial or complete loss of the ability to know what is real and what is not (such as hallucinations, delusions, paranoia)
- Inability to provide basic self-care
- Uncontrollable outbursts or aggressive actions that place a person with an I/DD or their environment at risk of harm
- Physical symptoms of withdrawal from drugs or alcohol or a realization that you need immediate help with an alcohol or drug problem

SHOULD I CALL MY PROVIDER IF I AM IN CRISIS?

Mental health emergencies are serious, but they do not always require a visit to the emergency department. Most mental health emergencies can be handled by calling your provider. If you are having a behavioral health crisis, your current treatment provider should speak to you immediately. Your provider should listen to your concerns and either give you guidance on what to do or arrange for you to receive emergency or crisis care. Your provider may refer you to a mobile crisis team.

Providers will also assist with post-stabilization services (offered after the emergency occurs). Post-stabilization services do not require pre-authorization, and Trillium helps ensure you receive the services you need.

If you do not have a life-threatening situation, you may also call your primary care doctor or your local Mobile Crisis Management (MCM) team (numbers on next page).

WHAT ARE MOBILE CRISIS TEAMS?

Mobile crisis services provide face-to-face counseling and supportive services during a crisis and can offer help for intoxication, drug withdrawal, impaired judgment, suicidal thoughts or other behavioral health crisis issues. Mobile crisis is not limited to Medicaid beneficiaries and is available to anyone in our 27-county region. Our contracted mobile crisis teams provide evaluation, treatment and referral for safe transfer to ensure appropriate support and services.

HOW DO I ACCESS MOBILE CRISIS SERVICES?

Mobile Crisis Teams are made up of experienced clinical staff well-trained in crisis prevention and stabilization techniques. If you experience a behavioral health crisis, a member of the Mobile Crisis Team will respond and meet you wherever it may be—at home, at school, at work or in the community.

Mobile Crisis Services:

- Provide evaluation, treatment and referral to safely transfer a person to appropriate supports and services
- Can offer help for intoxication, substance use withdrawal, impaired judgment or suicidal thoughts

You may directly contact the Mobile Crisis Team nearest you in the table to the right. Mobile crisis services can offer you face-to-face counseling and supportive services at the time of a crisis, **24 hours** a day, every day of the year, at no cost to you. Mobile Crisis Teams work for network providers who contract with Trillium.

If you are experiencing a medical emergency, ***call 911*** *and/or go to an emergency room at your local hospital.*

1-844-709-4097

RHA Health Services, Inc.
for the following counties:

Brunswick	*New Hanover*
Carteret	*Onslow*
Craven	*Pamlico*
Jones	*Pender*

1-866-437-1821

Integrated Family Services, PLLC
for the following counties:

Beaufort	*Hertford*
Bertie	*Jones*
Bladen	*Martin*
Brunswick	*Nash*
Carteret	*New Hanover*
Camden	*Northampton*
Chowan	*Onslow*
Columbus	*Pamlico*
Craven	*Pasquotank*
Currituck	*Pender*
Dare	*Perquimans*
Gates	*Pitt*
Halifax	*Tyrrell*
Hyde	*Washington*

WHAT SERVICES AND SUPPORTS ARE AVAILABLE?

In this section:

WHAT SERVICES AND SUPPORTS ARE AVAILABLE?

Trillium covers most publicly funded services for severe mental health, substance use and intellectual and/or developmental disabilities (I/DD). If you receive a category of Medicaid from one of Trillium's counties that qualifies and are not enrolled in a Standard Plan, you are automatically a member of the Trillium 1915(b)(c) Health Plan. Medicaid beneficiaries approved for an Innovations Waiver slot are members of the Trillium 1915(c) Health Plan. Trillium coordinates services as a managed care organization.

In general, we do not cover services for physical health needs. If you have Medicaid and you have questions about what services are available to meet your physical health needs, such as diabetes or high blood pressure, please call the N.C. Department of Health and Human Services' Customer Service Center (8 a.m. to 5 p.m., Monday through Friday) at 1-800-662-7030 (operators who speak Spanish are available). If you are assigned a Trillium care manager, he or she can help connect you with a primary care provider.

We are not responsible for services available through Medicare or TRICARE. If you have Medicare, call 1-800-MEDICARE (1-800-633-4227) or visit medicare.gov for more information. If you are a veteran or family member with access to TRICARE, call TRICARE's Northern Regional Contractor, Health Net Federal Services, LLC, at 1-877-TRICARE (1-877-874-2273) or visit tricare.mil or hnfs.com.

The state of North Carolina and our 28 counties also provide limited funding so that Trillium can pay for some people who cannot afford care to access certain services. If you are not eligible for Medicaid, you may be eligible to access our Non-Medicaid Health Plan. Non-Medicaid or state-funded services are not available for physical health care.

Behavioral health and I/DD crisis services are provided at no cost to any person. This includes individuals who have private insurance. If you have questions about services and your eligibility for them, call the Member and Recipient Service Line at 1-877-685-2415.

Available services are based on the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the N.C. Division of Health Benefits (DHB) service listings for Behavioral Health and Developmental Disabilities Services. Some services are available to all residents, regardless of insurance or Medicaid eligibility; see the State-Funded Services chart for more information.

State-Funded Services are either core services or non-core services. Core services are necessary for the basic foundation of any service delivery system. Core services are of two types: front-end services such as screening and assessments, and indirect services such as prevention, education, and consultation at a community level. Non-core services are those that do not fall within this description; view the State-Funded Services table for an exact list of services.

MEDICAID SERVICES	
BH, I/DD, and TBI Services Covered by BOTH Standard Plans and MCOs such as Trillium	***BH, I/DD, and TBI Services Covered EXCLUSIVELY by MCOs such as Trillium***
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 stabilitzation	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	Innovations Waiver services
Facility-based crisis services for children and adolescents	Respite
Supportive Employment	Community Guide
Long-term Vocational Support	Physician Consultation
Therapeutic Leave	

STATE-FUNDED SERVICES

**State-funded services are not an entitlement and are only available as long as funding exists.*

Disability Group	Core Services	Non-Core Services
All Disabilities	1. Diagnostic assessment 2. Facility-based crisis for adults 3. Inpatient BH services, including 3-way contract beds 4. Mobile crisis management 5. Outpatient services	1. BH urgent care 2. Facility based crisis for children and adolescents
Adult Mental Health	1. Assertive community treatment (ACT) 2. Assertive engagement 3. Case management 4. Community support team (CST) 5. Peer supports 6. Psychosocial rehabilitation 7. Mental health recovery residential services 8. Individual placement and support-supported employment (IPS-SE) 9. Transition management service	1. Partial hospitalization
Child Mental Health	1. High fidelity wraparound (HFW) 2. Respite	1. Intensive in-home 2. Mental health day treatment 3. Multi-systemic therapy
I/DD and TBI	1. Meaningful day and prevocational services 2. Residential services 3. TBI long term residential rehabilitation services 4. Supported employment 5. Respite	1. Developmental Therapy 2. Personal Assistance 3. Day Supports
Substance Use Disorder	1. Ambulatory detoxification 2. Assertive engagement 3. Case management 4. Clinically managed population specific high intensity residential services 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports 8. Substance use residential services and supports 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	1. Social setting detoxification services

AM I ELIGIBLE FOR MEDICAID SERVICES?

The 1915(b)(c) waiver services are available to individuals who receive Medicaid. To be eligible for Medicaid, you must:

- Be a U.S. citizen or provide proof of eligible immigration status (if you need emergency services, you are not required to provide documentation of immigration status)
- Be a resident of North Carolina and provide proof of residency
- Have a Social Security number or have applied for one
- Apply and be approved for Medicaid at your local Department of Social Services office, or online at epass.nc.gov

For Medicaid services, your local DSS decides Medicaid eligibility and any co-payment or deductibles. If you are unable to apply in person or online, you may print and mail your completed Medicaid application to your local DSS office. If you are currently receiving Social Security Insurance (SSI), Special Assistance to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled, you are automatically eligible for Medicaid and do not need to apply for Medicaid separately.

Disenrollment from Medicaid

There may be times when you are disenrolled in Medicaid. Trillium must report these events to the local Department of Social Services within **five days** *of learning the following:*

- Member being admitted to a correctional facility for more than **30 days**
- Member no longer qualifies for Medicaid or is ineligible for enrollment into the plan
- Member is admitted into an Institution for Mental Disease and is between the ages of 22 and 64, with the exception of "short term" admissions which are defined as no more than **15 calendar days** in a month
- Member passes away

ARE THERE LIMITATIONS TO MEDICAID ELIGIBILITY I SHOULD KNOW ABOUT?

Yes. Some Medicaid Categories of Aid are not covered under the Trillium Health Plan and remain under the N.C. Division of Health Benefits (DHB). DHB is the N.C. state agency responsible for managing the Medicaid program. Also, Medicaid regulations do not allow us to pay for services delivered to inmates of public correctional institutions or people in facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMDs), with the exception of "short term" admissions which are defined as no more than **15 calendar days** in a month.

This may include some Adult Care Home and Family Care Home settings. Please call your local county's Department of Social Services if you have questions about Medicaid eligibility. You should also know that federal regulations require Medicaid to be the "payor of last resort." This means that any claim for your services must be filed with third-party insurance policies, including Medicare and private health insurance, before Medicaid processes a claim. Your provider must report any other insurance payments for claims when filing for Medicaid payment.

WILL I BE REQUIRED TO PAY A CO-PAY IF I HAVE MEDICAID?

A "copay" or "cost sharing" is your part of any payments for health care services. If you are a Medicaid beneficiary, you cannot be charged a co-pay for any of the mental health, substance use, I/DD, or TBI services managed by Trillium. However, you can be charged a co-pay for physical health services or some prescriptions.

There are NO copays for the following members or services (per federal regulations):

- Members under the age of 21
- Members who are pregnant
- Members receiving hospice care
- Federally recognized tribal members
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- Children in foster care
- Children under Family Opportunity Act
- 1915(c) beneficiaries
- People living in an institution who are receiving coverage for cost of care
- Behavioral health, I/DD and TBI services

WILL I BE REQUIRED TO PAY A CO-PAY IF I DO NOT HAVE MEDICAID?

For recipients of State-funded (non-Medicaid) services, State law requires copayments, deductibles or other forms cost sharing for some individuals (based on family income) for mental health, substance use, I/DD, and TBI services. Physical services are not covered.

WHERE DO I OBTAIN A MEDICAID IDENTIFICATION CARD?

Your Medicaid Identification Card will be issued and mailed to your home address provided to DSS when you enrolled in Medicaid. This Medicaid Identification Card is your Trillium member card and will have Trillium's name and phone number printed on it. The N.C. Division of Health Benefits is the North Carolina state agency responsible for Medicaid.

WHAT IF I HAVE PRIVATE INSURANCE?

You should tell your provider if you have insurance other than Medicaid. This could include Medicare or private insurance. Federal regulations require Medicaid to be the "payor of last resort." This means that Medicaid pays for authorized services after your other private insurance has processed the claim and made a payment determination. If the Medicaid allowed amount is more than the third-party, Medicaid will pay the difference of your co-pay, co-insurance and deductible, whichever is less. If the insurance payment is more than the Medicaid allowed amount, Medicaid will not pay the additional amount.

HOW CAN I GET CARE FOR ADULTS AND CHILDREN WITHOUT MEDICAID?

To become eligible for non-Medicaid services, your provider must enroll you by calling the Member and Recipient Service Line at 1-877-685-2415. Eligibility for non-Medicaid services is based on income, citizenship and availability of other insurance and is limited to the services offered in the non-Medicaid benefit plan. If you request non-Medicaid services, your provider will ask you to share information about your annual household income to determine if you are eligible.

Non-Medicaid services are not an entitlement, and availability is based on funding Trillium receives from the state. Many of the services available through Medicaid are not covered under the non-Medicaid benefit plan, including residential treatment for children. Non-Medicaid funds cannot be used to pay for co-payments or deductibles under your primary insurance.

Non-Medicaid-funded services include:

Mobile Crisis Management
Diagnostic assessment
Assertive Community Treatment (ACT)
Various substance abuse services
Supported Employment

To find out if you may be eligible for non-Medicaid services, contact your provider or call the Member and Recipient Service Line at 1-877-685-2415.

WHAT SERVICES ARE AVAILABLE?

Providers will work with each individual to determine what types of services to provide. The services must be medically necessary, in the Trilllium Benefit Plan and either on the non-Medicaid-funded or Medicaid plan for the state of North Carolina. There are various types of services available to individuals with eligible Medicaid that are based on need, treatment history and the state's definition of medical necessity. These levels of service are either Basic or Enhanced. Services may be available either virtually (through an online, secure platform) or over the phone; please ask your care manager or provider for more information.

What are basic benefit services?

Basic benefit services are healthcare services designed to provide interventions for people with less severe mental health or substance use treatment needs. These services:

- Do not require a referral from another provider
- Reflect the least restrictive level of care
- Provide brief interventions for acute (immediate but short-term) needs
- Are available directly through a provider or by calling the Member and Recipient Service Line at 1-877-685-2415
- Require no prior authorization, unless you need more than the number of visits allowed under the applicable benefit plan
- Are not typically assigned to a Trillium care manager

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

What are enhanced benefit services?

Enhanced benefit services are intended to provide a range of services and supports that are appropriate if you are seeking to recover from more acute forms of mental illness or substance use, or to address your needs if you have an I/DD. These services:

- Include intensive services designed to support individuals to remain in their home
- Are accessed through the member's person-centered/individualized service planning process
- Require prior authorization
- Are highly coordinated to ensure you receive proper services without duplicating (copying) services

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

WHAT ARE INNOVATIONS WAIVER SERVICES?

NC Innovations is a Medicaid Waiver program for individuals with I/DD. It provides support to give individuals and families more control over their lives by offering a large array of service options to the members. A copy of the NC Innovations Waiver Individual & Family Guide can be viewed on our website.

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	

WHAT ARE INTEGRATED SERVICES AND UNMET HEALTH RELATED RESOURCE NEEDS?

Trillium understands that people may experience multiple obstacles. Trillium works to help people address all their behavioral health and I/DD needs, recognizing that many people have co-occurring issues. Our care managers and providers are able to work with our Neighborhood Connections team to assist members with accessing resources to help address needs such as adequate food and nutrition, safe and stable housing, employment and educational challenges, community inclusion and more. Unmet health related resource needs can play a large role in impacting your health.

Trillium has been addressing healthy opportunities in our communities for years. We take a person-centered, community-based approach to health and well-being, coordinating care across multiple systems to achieve improved health outcomes. Where a person physically and socially lives, learns, works, and plays all have a tremendous impact on their health. Through our work with local community based organizations around Eastern North Carolina, The Neighborhood Connections Team uses these relationships and NCCARE360, the first statewide coordinated care network, to connect members to available resources in their community.

If you would like to inquire about these resources, please call our Neighborhood Connections team at 1-877-685-2415.

WHAT BENEFITS ARE NOT COVERED BY TRILLIUM?

Please contact Trillium at 1-877-685-2415 to ask about services for specialty care that may not be covered by Trillium's Health Plan or Non-Medicaid-funded services. Examples of services that may be covered by other providers who accept Medicaid include: dental services, vision services (including eye glasses and contact lenses), and services with Child Developmental Agencies. Requests for services that are not included in the North Carolina Medicaid Plan may be covered under federal Medicaid law, if the individual is under 21 years old. Requests for non-covered services should be submitted by member's provider to Trillium using the appropriate form.

The "Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years Old" can be found on the Provider Documents & Forms page on Trillium's website. These requests will be reviewed by licensed and credentialed physicians.

HOW DO I LEARN ABOUT CHANGES IN SERVICES AND PROGRAMS?

Each service definition lists the exclusions for that service. For questions about exclusions from services, call our Member and Recipient Service Line at 1-877-685-2415.

Some examples of exclusions are:

- Services delivered by providers outside the Trillium Network are excluded from coverage, unless services are provided for a documented emergency.
- A service is excluded if it is not permitted to be provided at the same time as another. For example, Assertive Community Treatment (ACT) team may not be provided at the same time as Community Support Team (CST) or Psychosocial Rehabilitation (PSR).

Trillium will provide the member or recipient with written notification if any significant change occurs that requires modifications to the 1915(b)(c) Waiver, the DHB contract, the Medicaid State Plan, or program changes. Trillium will notify members/recipients at least **30 calendar days** before intended effective date of the change.

The Trillium Benefit Plan is published on the Trillium web site at www.TrilliumHealthResources.org/For-Individuals-Families Any changes to the Benefit Plan are documented in Clinical Communication updates, which are made available to the public and posted on the Trillium website.

WHAT IS EPSDT?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a part of the federal Medicaid law that requires Medicaid to pay for regular screenings and certain services for children and youths under age 21, even if the services are not included in the N.C. State Plan for Medical Assistance or the 1915(b)(c) Waiver. In North Carolina, the screening part of this program is known as "Health Check." Early treatment or awareness of an issue can prevent difficulties later in life.

Medicaid pays for services under EPSDT only if they are medically necessary to correct or ameliorate a defect, physical or mental illness or condition identified through the screening. The term "ameliorate" means "to improve or maintain the member's health in the best condition possible, to compensate for a health problem to prevent it from getting worse or to prevent the development of additional health problems."

The request must meet certain criteria for Trillium to approve it under EPSDT:

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

Requirements for prior approval apply to EPSDT services. If you are under age 21 or the parent of a child under age 21, services may be available to you or your child even if they are not covered under the Trillium Health Plan. Limits that apply to adult services do not apply to services under EPSDT.

Examples of services that could fall within EPSDT include:

- Medical and adaptive equipment
- Rehabilitative services for developmental disabilities
- Vision services
- Periodic screening services
- Other necessary health care

If you or your child has Medicaid, please talk to your provider or pediatrician to find out if the services needed may be covered under EPSDT. If your provider is not familiar with EPSDT or has questions, ask him or her to call the Member and Recipient Service Line at 1-877-685-2415. If you or your provider want to request a service under EPSDT that is not covered in the N.C. MH/DD/SA Health Plan and cannot be requested electronically through the Provider Portal, please call 1-877-685-2415, and a care manager can help you with your request.

If Trillium decides that a service requested for your Medicaid-eligible child does not meet EPSDT criteria, you will receive a formal written notice and appeal form with instructions. See **Section 10** of this handbook for more information about your appeal rights.

WHAT ARE VALUE-ADDED BENEFITS AND IN LIEU OF SERVICES?

Medicaid, Trillium, and other public programs provide many additional benefits that are not considered services, such as cell phone service or gym membership. These offerings can help ease access to health care or improve physical well-being. These are called "value-added benefits." They may be available to you based on your individual circumstances and if you meet the necessary requirements. Trillium coordinates value-added benefits through our Trillium Advantage program. Please call Trillium's Member and Recipient Service Line at 1-877-685-2415 visit our website to learn more about Trillium Advantage.

Through the 1915 (b)(c) Waiver, Trillium and other MCOs are given authority to develop services that are just as effective as and no more expensive than a State Plan Medicaid service. By creating new services, we are able to fill any gaps if there are not providers in the area who offer a particular service. Medicaid-funded services that meet this definition are called "In Lieu of Services" ("Lieu" is pronounced as "Loo").

While Trillium can create our own services tailored to the needs of members/recipients in our region, they still must be approved by NC DHHS and meet the strict requirements of medical-necessity and needs of the individual.

***Please note**: members have the right to request original state plan/waiver service instead of the ILOS if they choose.

Examples of Value Added Services	
Food Assistance	Mental Health First Aid classes
Lifeline cell phones	My Learning Campus
NC Care 360	Choose Independence
Transportation vouchers	Gym memberships
Future Planning: Special Needs and ABLE Accounts	

IN LIEU OF SERVICES (ILOS)		
Name of Service	***Definition***	***Service Replaced by ILOS***
Family Navigator	Advise families and people with I/DD or TBI to help them learn about the complex systems of services and supports by using their training and personal experience.	Intermediate Care Facilities (ICF)
Child First	Evidence-Based Practice (EBP) that helps to heal and protect children and families from the effects of chronic stress and trauma by fostering strong, nurturing, caregiver-child relationships, promoting adult capacity and connecting families with needed services and supports.	Intensive In-Home
High Fidelity Wrap Around	An empowering team of individuals and agencies working together to enhance the lives youth and their families.	Level II
Family Centered Treatment	Family Centered Treatment® (FCT) is a best practice, evidence-based modality of home-based treatment that was developed by practitioners over several decades. FCT has been gradually formalized into a model of home based treatment that has practice based evidence and evidence based practice shown to lower rates of out of home placements. It has been refined based on research, experience, and evidence of effectiveness derived from practice.	Residential placements, hospitalization, correctional facility placement and other community-based services
Community Living Facilities and Supports (CLFS)	Enables Trillium to provide comprehensive and individualized active treatment services to adults to maintain and promote their functional status and independence; includes five levels (CLFS Level 5 —CLFS Level 1)	ICF

HOW DOES TRILLIUM COORDINATE MY CARE?

In this section:

WHAT IS A SYSTEM OF CARE?

A System of Care (SOC) is a continuum of effective, community-based services and supports for individuals, children and families who have mental health issues and other life challenges. These services and supports are organized into a coordinated network and built on partnerships and collaboration.

The core values of a SOC require services to be:

- Culturally-competent, with agencies, programs and services that are informed, sensitive and responsive to the cultural, racial and ethnic differences of the populations they serve
- Community-based, with the focus of services, as well as the management and decision-making responsibility, resting at the community level
- Person-directed and family-focused, with the strengths and needs of the individual, child and family determining the types and mix of services
- Evidence-based to help ensure positive treatment outcomes

The Child and Family Team is an essential part of System of Care. The Child and Family Team:

- Is selected by the family
- Is made up of professionals, family members, friends and community supports who are committed to supporting the goals of the child and family
- Meets regularly and as needed to monitor the progress with the treatment plan

If you or someone you know wants to learn more about System of Care, please call Trillium's Administrative and Business Line at 1-866-998-2597 and ask to speak to the SOC coordinator in your area.

WHAT IS CARE MANAGEMENT?

Care management is a service offered to eligible members with special needs. Care management helps ensure that member with complex mental health, substance use or I/DD needs receive appropriate assessments and integrated treatment planning and are linked to the right services.

Care Managers work with you, your family and providers to:

- Assist members who are at high risk for hospitalization or institutionalization
- Assist members returning to the community who have been living in an institution, hospital or residential setting
- Manage your services across the continuum of care and link you to appropriate treatment
- Ensure that you receive appropriate clinical assessments and evaluations and have access to clinical and medical specialists
- Check on the health and safety of Innovations Waiver participants
- Develop a care plan

Care managers also work to involve everyone in your treatment/support team to ensure you receive integrated care planning to reach your fullest potential.

This includes:

- Providers you need to meet your treatment, habilitative and/or support goals,including your doctor, dentist or other healthcare providers that provide or support your care
- Representatives from county agencies or other people you identify who are working with you and your family.
- People who will support you even after certain services stop. These should be people you trust and call when you need help in your daily life who do not receive payment for their support.

WHAT ARE SPECIAL NEEDS POPULATIONS?

Special needs populations are made up of individuals with needs who require specialized services or higher levels of care (higher levels of care include enhanced services or additional hours). An individual is designated to have special health care needs based on a combination of their diagnosis and service needs determined in part through the use of standardized level of care tools like ASAM criteria, the LOCUS© and the CALOCUS©. ASAM stands for the American Society of Addiction Medicine. LOCUS© is the Level of Care Utilization System, and CALOCUS© is the Child and Adolescent Level of Care Utilization system. Both of these were developed by the American Association of Community Psychiatrists.

These tools, which help explore the severity of need, the effects of co-occurring health issues and strengths and supports, help Trillium determine the appropriate service level and eligibility for care management.

Designated special needs populations for I/DD care management include the following:

- Individuals enrolled in N.C. Innovations or who are Medicaid-eligible and on the Registry of Unmet Needs
- Individuals with an I/DD who are functionally eligible for the ICF-IID level of care but are NOT enrolled in N.C. Innovations or an ICF-IID facility
- Individuals with an I/DD who are currently in, or have been in within the past 30 days, a facility operated by the Department of Corrections (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom Trillium has received notification of discharge.

Designated special needs populations for mental health and/or substance use care management include the following:

- Adults with severe and persistent mental illness (SPMI) and current LOCUS© Level of VI
- Children with severe emotional disturbance or current CALOCUS© level of VI or are currently in, or have been in within the past 30 days, a facility operated by the DOC or DJJDP for whom Trillium has received notification of discharge
- Individuals who have a substance use diagnosis and current ASAM Level of III.7 or II.2D or higher
- Individuals with an opioid use disorder diagnosis who have reported to have used drugs by injection within the past 30 days
- Individuals with both a mental illness diagnosis and a substance use diagnosis and current LOCUS©/CALOCUS© of V or higher, or a current ASAM PPC Level of III.5 or higher
- Individuals with both a mental illness diagnosis and an I/DD diagnosis and a current LOCUS©/CALOCUS© of IV or higher
- Individuals with both an I/DD diagnosis and a substance use diagnosis and a current ASAM PPC Level of III.3 or higher
- Individuals identified in the U.S. Department of Justice Community Transitions to Community Living settlement (TCLI) who have serious and persistent mental illness and are transitioning out of an institutional-type residential setting to a community setting

WHAT IS THE TRANSITIONS TO COMMUNITY LIVING INITIATIVE (TCLI)?

The state of North Carolina entered into a settlement agreement with the U.S. Department of Justice (DOJ) in 2012. The purpose of this agreement was to make sure that people with mental illness are able to live in their communities in the least restrictive settings of their choice. The N.C. Department of Health and Human Services (DHHS) has implemented the agreement through the Transitions to Community Living Initiative (TCLI).

What are the components of TCLI?

- In-reach: Certified peer support specialists go into facilities and build relationships with individuals to discuss community-based mental health services and potential housing resources.
- Diversion: Referral Screening Verification Process (RSVP) is a screening tool used to determine if an individual is eligible for the TCLI program prior to any admission into an Adult Care Home.
- Transition planning: Once an individual is identified by in-reach as interested in community-based mental health or housing services, they are assigned to a transition coordinator. The transition coordinator helps develop a plan to transition an individual into the community.

Available services:

- Housing slots with financial rental assistance
- Tenancy support to help with moving, setting up household supplies and furniture and explaining what to do in an emergency
- Individual Placement and Support-Supported Employment service (for individuals with mental health and substance use disorders) to obtain competitive employment in an integrated work setting
- Work Incentives Planning and Assistance (WIPA) for individuals with disabilities who receive Social Security benefits to help acquire, retain and increase meaningful employment with the goal of improving financial independence
- Special Assistance-In Home provides cash supplement to help low-income adults who are at risk of placement in a licensed residential care setting to reside in a private living setting

Who is potentially eligible for TCLI?

As part of the DOJ settlement, NC DHHS has determined that the following members are potentially eligible for inclusion in the TCLI. Approval for inclusion in the TCLI Program is determined by the Referral Verification and Screening process (RSVP).

- Individuals with severe and persistent mental illness (SPMI) who reside in adult care homes that are determined to be Institutes of Mental Disease (IMD)
- Individuals with SPMI who reside in adult care homes licensed for at least 50 beds, and in which 25% or more of the population has a mental illness
- Individuals with SPMI who reside in adult care homes licensed for 20-49 beds, and in which 40% or more of the population has a mental illness
- Individuals with SPMI who are or will be discharged from a state psychiatric hospital, and who are homeless or have unstable housing
- Individuals diverted from entry into adult care homes pursuant to the pre-admission screening and diversion

For more information, please visit

www.ncdhhs.gov/transitions-community-living-initiative.

WHAT IS A BEHAVIORAL HEALTH HOME?

A Behavioral Health Home is the agency, determined by the primary service provider for the member, which will assist in development of a Person-Centered Plan, provide case management, and coordinate all other services. The behavioral health home is usually your primary provider. This provider will help you develop your person-centered plan. This provider may offer a variety of services.

WHAT IS A PERSON-CENTERED PLAN? (PCP)

Person-centered planning is a tool of the Trillium Health Plan that helps members exercise choice and responsibility in the development and implementation of their care plans. It helps define what is important to the person and it encourages individuals to have real and honest discussions with their clinical and support teams about their desires, needs and supports. It can occur annually or anytime an individual experiences significant life changes.

The Person-Centered Plan (PCP) helps individuals reach their fullest potential by:

- Ensuring that the individual has maximum social participation and inclusion in the community
- Providing an opportunity for members to guide their care plans, with assistance from family, friends and professional service providers
- Incorporating a variety of supports, including training, therapy, treatment and other services needed to achieve the individual's personal goals
- Drawing upon a diverse mix of resources, including paid and natural supports, to best meet the individual's goals

The PCP should clearly express the voice of the person. All PCPs:

- Are respectful of the person and those who support the person
- Are easy to read and understand and use everyday language
- Are constructed so that information is located easily
- Use complete thoughts but not necessarily complete sentences.
- Have enough detail and/or enough examples to be easily understood by someone who has not known the individual for very long.

The phases of completing the PCP are:

- Gathering information/assessment
- Organizing the information for team review/team meeting
- Developing the PCP
- Requesting approval of services within the PCP
- Implementing the PCP

When you take responsibility of your own treatment and help your providers know what works for you, Trillium believes you will have more success at recovery and improving your well being.

In developing a PCP, you should consider:

- What has been happening in your life over the past year?
- What do you want your life to look like?
- Do you want to volunteer or work at a paid job?
- Where do you want to live and with whom?
- What would make where and how you live better?
- What supports do you need to maintain the important things in your life?
- What would you change about your life if you could?
- What part of the day do you like best and why?
- Do you have enough money to pay for all the activities you would like to do?
- What kind of person makes the best support person for you?
- How is your health? Do you have concerns about your general health?

WHAT IS AN INDIVIDUAL SUPPORT PLAN (ISP/CARE PLAN)?

If you are an Innovations Waiver participant, you will develop an ISP/care plan with your assigned care manager who will help manage your care, link you to needed services and supports, and perform regular visits to make sure you are healthy and safe. The ISP/care plan packet describes you as a person, your likes, your dislikes, what is important to you, your goals and the services and supports you need to live an integrated life in the community of your choice.

What should I know about the ISP process?

- The care plan covers up to a 12-month period that runs from the first day of the month following the participant's birth month to the last day of the month of the birth month. Your care manager will contact you to schedule a planning meeting in the weeks prior to your birth month.
- During the planning process, your care manager will explain the different services to you and the benefit limits and requirements in the Innovations Waiver for those services.
- Your care manager will work with you, your natural supports and your provider to develop your care plan that includes the services/supports you want to request, for the length of time you want to request them.
- The care plan should be used to plan for the entire year and include any services/supports you expect to need at any point during the year.
- If you wish to change or add services during the plan year, you may ask your care manager to help you request the change by writing an update to your care plan at any time.
- Your care manager will draft the care plan based on your wishes and needs, review the plan with you before you sign it, answer any questions you have and make any changes to the plan that you request before you are asked to sign it.

- Your care manager will never ask you to sign a plan that does not contain the services/supports you want. If you think you will need the services for the entire plan year, you will not be asked to sign a care plan that does not request those services for the entire plan year.
- You or your legally responsible person (referred to as an LRP) must sign the care plan once it is complete. You must have a signed care plan to receive services through the Innovations Waiver. This means that you need to sign the care plan containing the level of services that youwant to request.
- A medical necessity review of the services and supports requested in your care plan packet is completed by Trillium's Utilization Management Department, which will make a decision within **14 days**, unless more information is needed. That department is separate from Trillium Care Management. Your care manager does not make the decision about whether the services you request are medically necessary.
- If any service requested in your care plan packet is not fully approved, you will receive a written explanation of that decision and information about how you can appeal the decision.

HOW DO I FIND A PROVIDER FOR MY CARE?

In this section:

- How do I choose a Provider, Specialist or Subspecialist?
- How do I change providers?
- How does Trillium ensure quality services?
- What types of providers are available in the Trillium network?
  - Agencies
  - State-Operated Healthcare Facilities
  - Licensed Independent Practitioners and Group Practices
  - Hospital Facilities
- Where are providers located?
  - Emergency Services
  - Out-of-area or out-of-state providers
  - Out-of-network providers
  - How do I get care from an out-of-network provider?
- How do I pay for my care?
- Can I get help with transportation to appointments?
- What is the Human Rights Committee?
- What is cultural competency?

HOW DO I CHOOSE A PROVIDER, SPECIALIST, OR SUBSPECIALIST?

Trillium contracts with providers in our network (in-network providers) to cover services. These providers have verified credentials and have agreed to follow medically necessary criteria and Medicaid requirements. Providers can be specialists including psychiatrists or counselors, or subspecialists who focus on alcoholism or medication management.

There are three ways you can choose a provider, specialist, or subspecialist:

1. Visit TrilliumHealthResources.org, select the "Find a Provider" button at the top of the screen, and review our online directory to choose your own provider. You can search by diagnosis, specialty, location, and more.
2. Call Trillium at 1-877-685-2415 to ask for assistance in finding a provider.
3. Visit a provider of your choice who will then contact Trillium to determine if services are covered. These providers may be "out-of-network," please see **page 41** for more information.

When you call Trillium to access services, you will be offered a choice of at least two providers. In most cases, we can provide information to help you choose a provider.

A provider who has met the established criteria for enrollment and provides services within the counties Trillium covers, is eligible to be part of the provider network and is considered an in-network provider. A network provider has a contract with us to provide services. Trillium does not offer any physician, practitioner, and/or provider incentive plans to anyone in our provider network.

The information we give you about a provider includes:

- Provider name
- Provider address/locations
- Telephone numbers
- The services the provider provides (type or category)
- Provider qualifications
- If the provider is accepting new patients (sometimes listed as "referrals accepted")
- Insurance type accepted (Medicaid or non-Medicaid)
- Provider specialty (such as mental health, etc.)
- Residency information and board certification (if available)
- Special accommodations provided, such as wheelchair access, assistance for hearing impaired and languages spoken or translators available
- Availability within 30 miles or 45 miles, based on whether you live in an urban area (like a town or city) or rural areas (such as unincorporated areas outside of city limits in the "country")
- Cultural diversity training completed by the provider, if available

Ask friends, relatives, doctors, and others you trust about whom they would recommend as therapists or service providers. Building a relationship with your provider enhances the quality of care. Providers should treat you as an individual, not as a diagnosis. You deserve a meaningful therapeutic relationship and good quality care.

We also offer an online provider directory on the Trillium website: www.trilliumhealthresources.org/for-providers/provider-directory. You can also call Trillium at 1-877-685-2415 and ask for a copy to be mailed to you.

Some suggestions regarding choosing a provider are:

- Select a provider when you are feeling well and are able to communicate your needs effectively
- Look for willingness to answer your questions
- Search for a provider who is aware of the secondary conditions you may have, such as diabetes, lung conditions, hepatitis or heart disease
- Try to find a professional who is willing to be part of a team to work with you to be as healthy as you can be

Once you choose a provider, take the following with you to your first appointment:

- A list of your medications (prescribed and over-the-counter)
- A list of your hospitalizations and a list of programs you have attended (along with if you remember them)
- A copy of your Medicaid ID card and, if applicable, other insurance card
- A list of any secondary conditions like those listed above
- Most appointments with a doctor or psychiatrist will only last **15 to 20 minutes**. You can request a longer appointment if you are having particular concerns.

HOW DO I CHANGE PROVIDERS?

Within our provider network, you have the right to change providers. You have the right to consider providers you are currently using and request a change if needed by calling 1-877-685-2415 or speaking to your care manager. Trillium strives to have enough providers enrolled in the network to offer choices to members.

When a provider leaves the network (either by choice or otherwise), Trillium will contact all members currently in treatment with the provider. Trillium will make every effort to notify each member in writing **thirty (30) days** prior to the provider leaving the network. If Trillium learns of a provider's departure less than **thirty (30) calendar days** before termination date, Trillium will make every effort to notify each member in writing **fifteen (15) calendar days** after Trillium receives notice of the termination or within **fifteen (15) calendar days** after Trillium terminates the provider.

HOW DOES TRILLIUM ENSURE QUALITY SERVICES?

It is our responsibility to closely monitor providers who deliver your services and supports. All providers in the Trillium network must complete a comprehensive application process including credentialing, confirmation with the N.C. Division of Health Benefits (DHB) on any existing provider issues and onsite visits. We also conduct complaint investigations, focused monitoring and post-payment reviews of providers in our network to ensure quality care and prevent fraud and abuse of public funds.

Our Network Auditing Team investigates all complaints received about providers in our network, whether those complaints come from you, family members, community stakeholders or our staff. If we substantiate a complaint, the provider may be asked to implement a plan of correction. Or, we may take action against the provider, up to and including termination from our provider network. We also monitor critical incidents filed by our contracted providers in the N.C. Incident Response Improvement System (IRIS).

We also have a Program Integrity Team made up of certified investigators who investigate allegations of fraud, waste and abuse in our Medicaid managed care program. This team identifies and recovers overpayments made to providers in our network and refers allegations of fraud to the Medicaid Investigations Division of the N.C. Attorney General's Office. These investigations are confidential.

We are committed to a robust Quality Management (QM) program that ensures access to care, a well-qualified provider network and a comprehensive array of clinically appropriate behavioral health and I/DD services that meet quality standards. This program helps make sure your services are high-quality, including services provided in outpatient, inpatient/hospital, residential and community-based settings. Our Quality Improvement Committee explores way we can improve with projects to address access to care, quality of care, and network provider performance.

WHAT TYPES OF PROVIDERS ARE IN THE TRILLIUM NETWORK?

Agencies

An agency-based provider is a business (for-profit or not-for-profit) that provides mental health, I/DD and/or substance use services. Employees of the agency provide the service to the member, and agency management assures the employees meet the qualifications to provide services and meet all other requirements of the contract between Trillium and the agency-based provider. Employees who are licensed practitioners must be credentialed by Trillium.

State-Operated Healthcare Facilities

The state of 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. These facilities have a separate admissions process and are not listed in Trillium's provider directory.

Licensed Independent Practitioners and Group Practices

Licensed independent practitioners (LIPs) and group practices include:

- Medical Doctors
- Practicing Psychologists (PhD)
- Licensed Psychological Associates (LPA)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Clinical Mental Health Counselor (LCMHC)
- Licensed Clinical Addiction Specialists (LCAS)
- Advanced Practice Clinical Nurse Specialists
- Psychiatric Nurse Practitioners
- Licensed Physician Assistants

These practitioners and group practices contract with Trillium and are part of the Trillium network. Group practices are groups of practitioners who have created a corporate entity for billing purposes. These practitioners usually share office space and offer only outpatient therapy services.

Hospital Facilities

Hospitals with inpatient psychiatric facilities and/or outpatient psychiatric programs are also enrolled in the network. Hospitals outside of the Trillium network (either do not contract with Trillium or are not in our region) that provide emergency services to members with a behavioral health discharge diagnosis are paid for these services under an out-of-network agreement.

WHERE ARE PROVIDERS LOCATED?

Most services will be available within 30 miles from your home through in-network providers. However, some specialty providers may be located in another county. Trillium will assist you in locating a provider that can meet your needs, as close to your home as possible.

Emergency Services

You have the right to access emergency services and post-stabilization care at any location that provides emergency care without prior authorization from Trillium. If inpatient hospitalization is needed, your care will routinely be reviewed for medical necessity.

Out-of-area or out-of-state providers

An out-of-area provider is a provider who has met the Trillium credentialing process, meets all criteria for enrollment, and has a contract to provide services but is located and provides services outside of the 28 counties in the Trillium region. This includes providers who are located out of state.

Out-of-network providers

If you have contacted a provider for services who is not part of the Trillium provider network and wish to continue to be seen by this provider, you will need to make arrangements to pay the provider directly.

If a member travels out of the Trillium area and needs to visit a provider not in the Trillium network for non-emergency treatment, the member is allowed to do so. The provider will be responsible for contacting Trillium to set up the necessary paperwork to receive payment. Members who need crisis services or emergency treatment can visit any emergency room or mobile crisis provider at no cost.

How do I get care from an out-of-network provider?

Trillium normally does not cover services by out-of-network providers unless it is an emergency situation and you cannot be safely transferred to an in network provider. Another exception is for any treatment not provided by an in network provider. Out-of-network providers do not have a contract with Trillium, but still must meet criteria for medical necessity in any services they recommend for a member/recipient. They also must meet all requirements from NC DHHS and Trillium for serving as a provider/practitioner.

Admission to an out-of-network facility, specialist, or program will be authorized for payment only if:

- You cannot be safely or appropriately transferred to a network facility/program, and/or;
- Appropriate care is not available from an in-network facility or specialist.

Authorization of payment for services in an out-of-network facility will continue until you can be safely and appropriately transferred to a network facility or program. Trillium will only pay for services that are previously authorized (except for mobile crisis or emergency services).

If Medically Necessary Treatment is required, but specialty services are not available in-network, you can visit an out -of-network provider for these services at no cost (or benefit penalty) to the member.

HOW DO I PAY FOR MY CARE?

For services to be paid in whole or in part by Trillium, you must be enrolled in the Trillium system. If you have any questions about eligibility, please call the Member and Recipient Service Line at 1-877-685-2415. For quesions about eligibility for Medicaid, call your county's Department of Social Services office. Some non-Medicaid services (state-funded, mobile crisis management, etc.) are provided at no cost. Members are not required to submit any claims for payment on behalf of the provider. Members may be expected to pay for some services (called a "copayment") but cannot be turned away for service if they cannot pay. You will be told when you make the appointment if a copayment is necessary.

CAN I GET HELP WITH TRANSPORTATION TO APPOINTMENTS?

If you receive Medicaid, you can use Non-Emergency Medical Transportation (NEMT) to and from the doctor's office, the hospital, or another medical office for Medicaid-approved care.

This service is available in counties Trillium serves. Contact your local DSS office to find out how to use this service. You can also call Trillium at 1-877-685-2415 for help contacting your local DSS office. There is no fee for people enrolled in Medicaid. For people not enrolled in Medicaid, transportation depends on available space and may cost only a few dollars, depending on the DSS office.

WHAT IS THE HUMAN RIGHTS COMMITTEE?

The Trillium Human Rights Committee protects the rights of people receiving services. The committee is made up of members, family members and board members. Your provider should also have a Human Rights Committee as required by their contract with Trillium. Call Trillium or your provider for additional information.

Providers must have a process that lets you submit complaints and grievances about your services. Providers must document all complaints received and must refer any unresolved concerns or complaints to Trillium. Providers must share their complaint and grievance process with you when you first start receiving services or whenever you request a copy. They also must inform you of your rights and responsibilities.

WHAT IS CULTURAL COMPETENCY?

We want our service system to reflect the uniqueness of our local communities, improve the quality of services and support members to shape the choices available. Cultural competency means "the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds." Trillium encourages our provider network to develop cultural competency to provide the highest quality of care to all people. Trillium staff complete a similar training.

We want our providers to achieve the following goals related to cultural competency:

- Providers will become more involved in the community of people served. This may include participating in community events, focus groups, and community advisory councils.
- Providers and their staff will become more aware of ethnic, racial, regional, and cultural differences to help develop a respectful service delivery free of offensive practices or conditions.
- Providers and their staff will become better educated on how best to deliver services to culturally and ethnically diverse people and on how to eliminate barriers to treatment, such as language and interpretation.

If you believe staff serving you does not understand your language or your religious, cultural, educational, or social background, you have the right to ask about changing staff to better meet your needs.

HOW DOES TRILLIUM MAKE DECISIONS ABOUT MY CARE?

In this section:

- What is prior authorization?
  - Emergency and Crisis Services
- How long does Trillium take to make a decision about my request?
- What is medical necessity?
- What other guidelines does Trillium follow?
- What is peer review?
- What happens if the service I need is not available?
- Can I request a new treatment or service?
- What is the NC Medicaid Ombudsman Program?

Federal Medicaid regulations require us to review authorization requests and make decisions about whether the services your provider is asking for are medically necessary. This process helps us keep track of the type and amount of services and how often they are used. Our Utilization Management (UM) Department is staffed by experienced clinicians who review requests for services. They make decisions to ensure you get the right care, in the right amount, at the right time.

Trillium does not offer incentives that would discourage requests or approvals for services. Trillium does not offer incentives for utilization management staff or contractors to deny, reduce, terminate (end), suspend (pause), limit, or discontinue medically necessary services for any member. We also do not offer physician, practitioner, and/or provider incentive plans.

Our decision-making is based on your eligibility, your needs, your treatment history and whether the requested service is medically necessary and meets the requirements of applicable rules. These rules include the N.C. State Plan for Medical Assistance, 1915(b)(c) Waiver criteria, clinical coverage policies, service definitions, benefit plan restrictions and Clinical Practice Guidelines. For Medicaid beneficiaries under age 21, we also review requests against Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria. EPSDT is explained in Section 5.

Clinical coverage policies and service definitions are issued by the N.C. Division of Health Benefits (DHB) and the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). **They are not created by Trillium and are subject to change with relatively short notice.** Each service definition lists the criteria, limits and exclusions for that service that Trillium must follow when reviewing requests for authorization.

For more information about the N.C. State Plan for Medical Assistance or N.C. Medicaid Clinical Coverage Policies, visit the DHB website at medicaid.ncdhhs.gov. For questions about limits or exclusions on services, call Trillium at our Member and Recipient Service Line at 1-877-685-2415.

WHAT IS PRIOR AUTHORIZATION?

Medicaid requires that we review and authorize some services before they are provided. Authorization covers the dates and amounts of services provided.

Your provider should know which services require prior authorization, or you can call our **Member and Recipient Service Line at 1-877-685-2415** for more information.

Providers request services by completing a Treatment Authorization Request (TAR) form via Trillium's software platform. Your provider is responsible for including documentation to show that the service is necessary for you.

Remember that it is important to attend your appointments within the authorization timeframe. Once you are past the dates for your authorization, you will need to get additional authorizations for services from Trillium even if you did not use all the services that were authorized.

The following services are some examples that do not need a referral or prior-authorization:

- Mobile Crisis Services
- Physician Consultations
- Evaluation and Management
- Children's Screening Services

Emergency and Crisis Services

Crisis services are always provided in an emergency. Trillium will reimburse providers for documented emergency or crisis services at any time without regard to prior authorization or whether the provider is enrolled in the Trillium network. Non-Medicaid recipients who receive emergency or crisis services will be enrolled in the Trillium Health Plan as soon as possible.

The date of enrollment will become the date the emergency or crisis services were provided. You must be enrolled in our system before you can receive additional, non-emergency services.

HOW LONG DOES TRILLIUM TAKE TO MAKE A DECISION ABOUT MY REQUEST?

TIMEFRAME FOR COMPLETION OF THE CLINICAL REVIEW ARE AS FOLLOWS:	
Urgent – 72 hours	*Non-urgent – 14 calendar days*
For urgent and non-urgent cases, Trillium may extend this period one time for up to1 4 calendar days and may be requested by a member or a provider in writing:	
a. If Trillium determines an extension is necessary because of matters beyond its control; and	
b. If Trillium 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	
c. 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.	

WHAT IS MEDICAL NECESSITY?

People receiving care must meet medical necessity criteria for the amount and duration of the service requested to address their specific condition. Individuals without Medicaid who are eligible and meet medical necessity criteria will receive services to the extent that funding for non-Medicaid services is available. We use medical necessity criteria when determining appropriate care for Trillium Health Plan members.

Medically necessary treatment includes procedures, products and services that are:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative or restorative treatment of a mental health or substance use condition
- Necessary to address areas of difficulties such as self-care, communication, mobility, decision-making, independent living and financial self-sufficiency
- Consistent with Medicaid clinical coverage policies and national or evidence-based standards, bulletins, standards or other guidance issued by the Centers for Medicare & Medicaid Services (CMS), the N.C. Department of Health and Human Services (DHHS) or its divisions or verified by independent clinical experts at the time the procedures, products and the services are provided
- Provided in the most cost-effective, least restrictive environment that is consistent with good clinical standards of care
- Not provided solely for the convenience of you, your family, caregiver or provider
- Not for experimental, investigational, unproven or solely cosmetic purposes

list continued on next page

- Furnished by or under the supervision of practitioners licensed under state law in the specialty for which they are providing services and in accordance with the N.C. State Plan for Medical Assistance, the North Carolina Administrative Code, Medicaid clinical coverage policies and other applicable federal and state laws, rules, regulations and directives
- Sufficient in amount, duration and scope to reasonably achieve their purpose
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity and duration of service and treatment settings

Medically necessary treatment is designed to:

- Be provided along with a Person-Centered Plan based upon a comprehensive assessment and developed with you or with a child, the child's family (or legal guardian) and community team
- Be provided along with an Individual Support Plan
- Conform to any advance directive that you have prepared
- Respond to the unique needs of linguistic and cultural minorities
- Prevent the need for involuntary treatment or institutionalization

If you aren't reaching your goals with a service that is considered low level you may still be eligible for a higher level service.

Examples of services that are not medically necessary include:

- Purely cosmetic surgery including liposuction and tummy tucks
- Infertility treatments
- Weight loss or weight gain drugs
- Child care without a treatment component

While the services may be medically necessary, Trillium will deny claims for services for which you need a referral in advance and you did not get it and services for which you need prior authorization in advance and you did not get it.

WHAT OTHER GUIDELINES DOES TRILLIUM FOLLOW?

Our UM Department uses clinical practice guidelines, clinical decision support tools (such as the LOCUS©, CALOCUS©, CANS, ASAM, SIS®, NC-SNAP, and Early Childhood Service Intensity Instrument (ECSII) and other clinical standards to evaluate whether care is effective and appropriate. Providers use these guidelines as a road map for effective evidence-based care.

We also encourage you to use these guidelines to help make choices about treatment decisions. Practice guidelines are meant to improve care by helping you and your provider make good clinical decisions. They are based on research, published by well-known organizations, such as the American Psychiatric Association, and have been shown to help people with their problems. The guidelines we use are approved by a local committee of people receiving services, family members, staff and clinical professionals.

For a full listing of utilization management criteria, or to request a copy of our Clinical Practice Guidelines, call our Member and Recipient Service Line at 1-877-685-2415 or visit www.Trilliumhealthresources.org. If you feel your provider is not following these guidelines, please call 1-877-685-2415 and let us know about your concerns. If you don't tell us about your concerns, we cannot improve the care you receive.

WHAT IS PEER REVIEW?

If our utilization management clinicians determine the requested service does not meet criteria, the request will be reviewed by a licensed psychologist or medical doctor (peer reviewer), to make a final decision. Only peer reviewers can decide to deny, reduce or terminate a service requested for you.

In some cases, other levels or kinds of services may be recommended. If Trillium decides to deny, reduce or terminate a service requested for you, we will send you or your guardian a notice in writing with instructions and a form for filing an appeal. Section 10 of this handbook provides detailed information on how to appeal. Our goal is to ensure that people receive the right type and amounts of service at the right time, using the most effective and efficient treatment possible.

WHAT HAPPENS IF THE SERVICE I NEED IS NOT AVAILABLE?

If you have Medicaid, we will try to find an in-network provider for your care. If no in-network provider is available, we will work hard to find an out-of-network provider. It is our job to make sure providers are available for you.

We will only place you on a waiting list for services if one of the following applies:

- You are asking for an Innovations Waiver service and are not on the Innovations Waiver (spaces on this Waiver are allocated by the state, and Trillium has no control over the number of spaces available)
- Demand for services exceeds available resources (non-Medicaid/state-funded services only)
- There is no provider available for a service (for example, if all residential or inpatient beds are full)

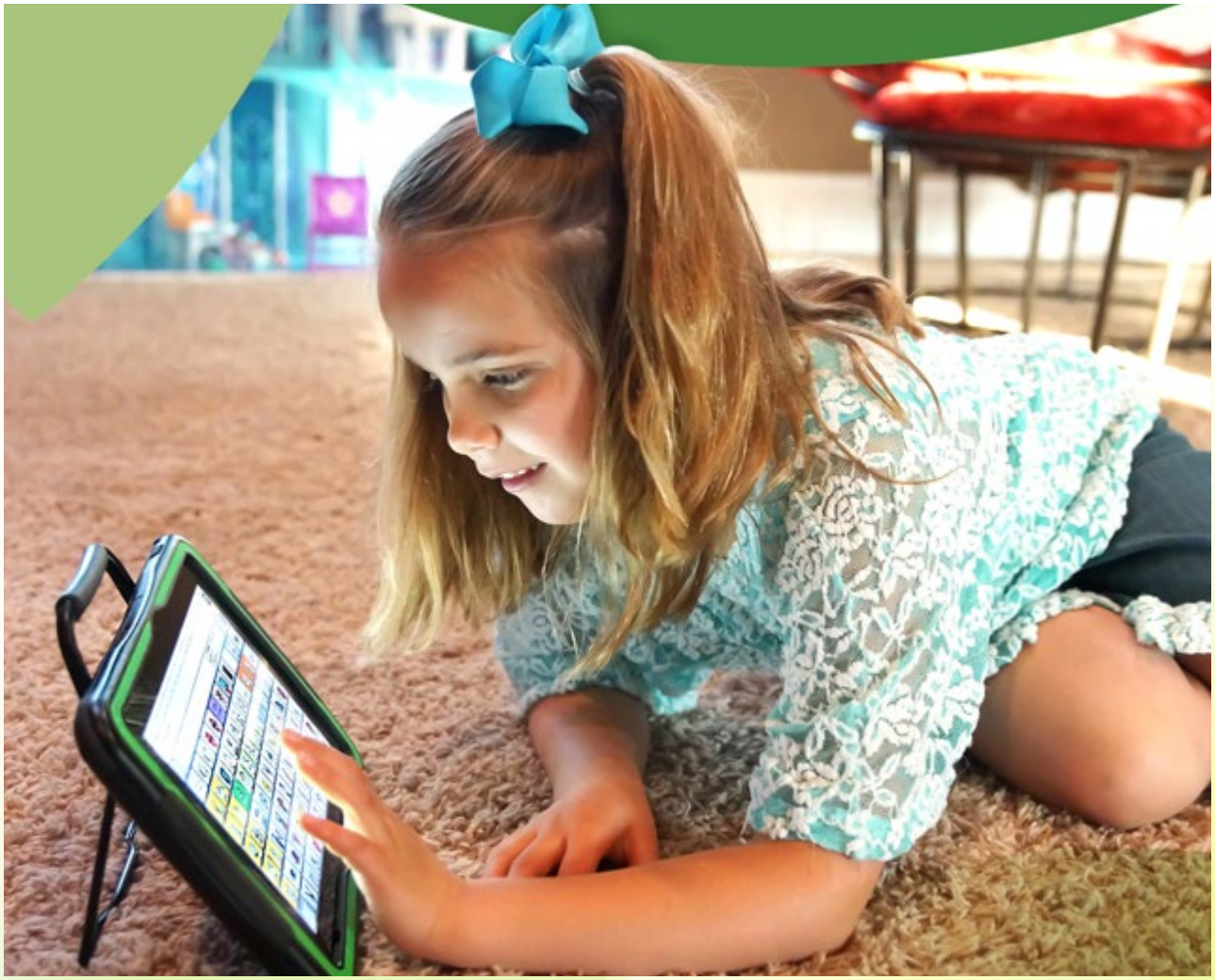
Trillium maintains a waiting list for residential and inpatient services at capacity or non-Medicaid services subject to funding limitations and is notified when providers report openings or funding for services becomes available. The team then identifies potential candidates from the waiting list.

The following factors are considered when selecting people from the waitlist for services:

- Service need
- Risk factors such as health and/or safety issues
- Risk of hospitalization or a higher level of care if the need is not addressed
- Whether the resources identified are adequate to meet your needs
- If other funding sources are available to meet your needs
- Length of time you have been waiting
- For group settings, the compatibility with other people receiving treatment; in some cases, people in residential settings are given choices over preferred housemates (adult services).

You will then be given a list of qualified providers and may select from that list. If the opening is within an identified program, the program receives a list of eligible individuals.

The provider's admissions process will screen applicants and make a selection based on the factors identified above. Individuals referred from regional developmental centers, state mental health facilities or state substance use facilities will be given equal consideration for community referrals. Bringing people back to the community is a high priority for Trillium.



CAN I REQUEST A NEW TREATMENT OR SERVICE?

Trillium is always interested in learning about new treatments or therapies to determine if they should be covered benefits. We review new behavioral health advances, government studies and peer-reviewed research as they are made available to determine if experts have agreed that new treatments are safe and effective.

New proven therapies and treatments must result in outcomes that are as good as, or better than, covered benefits currently offered by Trillium. You may call your care manager anytime you have a need for a new treatment, service, or support. If you do not have an assigned care manager, you can call 1-877-685-2415 to ask Trillium to consider a new service. Our Clinical Advisory Committee (CAC) develops our clinical practice guidelines that are reviewed annually. The CAC does not review individual requests for new treatments; the guidelines are used for clinical management and not specific services.

WHAT IS THE NC MEDICAID OMBUDSMAN PROGRAM?

The NC Medicaid Ombudsman Program serves members around the state of North Carolina (not just 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 is tasked with:

- Serving as a central resource to resolve issues within the Medicaid Managed Care delivery system;
- Providing information about NC Medicaid and the Medicaid Managed Care Program;
- Support access to care by making referrals to and collaborating with other resources including but not limited to State agencies, Department partners, community-based advocacy, and legal services organizations;
- Identifying trends or systemic issues in delivery system performance; and
- Supporting the Department's vision of creating a healthier North Carolina.

Members and their guardians can reach out to the Ombudsman Program using the contact information below:

Legal Aid of North Carolina
www.NCMedicaidOmbudsman.org
info@ncmedicaidombudsman.org
1-877-201-3750
224 S. Dawson St., Raleigh, NC 27601

WHAT ARE MY RIGHTS AND RESPONSIBILITIES?

In this section:

- What are my rights?
- If I am a minor, do I have any rights?
- What are my responsibilities?
- What are my rights in a 24-hour facility or adult care home?
- What are my rights if I have an Intellectual/Developmental Disability?
- What are restricted rights?
- What do I do if I believe my rights have been violated?
- What is informed consent?
- What if I am unable to make a decision about my care?
  - Psychiatric Advance Directives
  - Health Care Power of Attorney
  - Living Will
  - What do I do with my Advance Directives?
  - How long do my Advance Directives stay active?
- Do I lose my rights if I have a guardian?
- Can I have my competency restored?
- What are my privacy rights?
- Are there any rights that protect me if I go to jail?

If you get Medicaid from any of the counties in the Trillium region, you are a member of the Trillium Health Plan. As a member of the Trillium Health Plan, you have rights and responsibilities for your care. You are free to exercise your rights and the exercise of those rights shall not adversely affect the way that Trillium or its providers treat you.

WHAT ARE MY RIGHTS?

N.C. General Statutes, Administrative code, and federal regulations outline rules and regulations about human rights; you are allowed:

- The right to request and receive information about Trillium, its services, its providers/practitioners, and member rights and responsibilities presented in a manner you can understand. Trillium notifies members of this right, annually.
- The right to be treated with respect and recognition of your 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. You may need to decide among relevant treatment options, the risks, benefits and consequences, including your right to refuse treatment and to express your 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. You can do this by calling Member and Recipient Service Line at 1-877-685-2415 or visiting the website and clicking on "Contact Us" at the top of the page.
- The right to appeal decisions with which you disagree.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. If you present a danger to yourself or others, and there are no other means available to protect your safety and the safety of others, physical restraint may be used.
- The right to request and receive a copy of your medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. Therapeutic privilege means if the doctor or therapist determines that this would be detrimental to your physical or mental well-being, you can request that the information be sent to a physician or professional of your choice.
- The right to write a statement to be placed in your file if you disagree with what is written in your medical records. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SAS 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 **thirty (30) days** after services start. This is known as your 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 you. Upon request, Trillium shall provide one second opinion from a qualified health care professional selected by Trillium, at no cost to you. 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 you 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 your treatment plan and toconsent 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 you do not understand your care or what you are expected to do.
- The right to written notice of any "significant change" to the handbook 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 1915 b/c Waiver, this Contract 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
- You have the right to develop an Advance Directive for the mental health treatment you would like in the event of an emergency. You may contact Trillium Health Resources for assistance at 1-877-685-2415. An Advanced Directive explains the treatment you would like and the people you would like to be involved. It also explains the things that you do not want. You have the right to file a grievance with the N.C. Division of Health Service Regulation or with Trillium if you feel the laws governing the advance directives have not been followed correctly.
- You are free to exercise these rights and the exercise of these rights shall not adversely affect the way Trillium or its providers treat you.
- You have the right to be free of mental abuse, physical abuse, neglect and exploitation.
- You have the right to choose your Provider from the Trillium Provider Network. You have the right to change your choice of Provider at any time by calling 1-877-685-2415 or speaking to your care manager. When a provider leaves the network (either by choice or otherwise), Trillium will contact all members currently in treatment with the provider. Trillium will make every effort to notify each member in writing **thirty (30) days** prior to the provider leaving the network. If Trillium learns of a provider's departure less than **thirty (30) calendar days** before termination date, Trillium will make every effort to notify each member in writing **fifteen (15) calendar days** after Trillium receives notice of the termination or within **fifteen (15) calendar days** after Trillium terminates the provider.
- You have the right to treatment, regardless of your age or disability. The treatment you receive will be age appropriate and in the least restrictive manner possible.
- You have the right to invite family or friends to help develop your Person-Centered Plan. The purpose of the Person Centered Plan is to help you make goals to achieve your full potential.

list continued on next page

- You have the right to be notified in advance of all potential risks and benefits of treatments.
- You have 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.
- You have the right to refuse medications. This should always be discussed with your doctor.
- You **CANNOT** be treated with electroshock therapy, experimental drugs or procedures, or be given surgery (unless it is an emergency surgery) without your written permission.
- You have the right to make recommendations regarding Trillium policies, procedures and services. If you would like to make recommendations regarding changes, please contact Trillium Health Resources at 1-877-685-2415. You may also write us at:
  Trillium Health Resources
  201 West First St.
  Greenville, NC 27858
- You have the right to keep your care and medical records confidential. Even the fact that you are receiving services is confidential.

Information about you can only be shared when:

- You have given written consent
- There is a court order
- You become a danger to yourself or others and it is necessary for someone to submit involuntary commitment papers or find hospital placement for you
- You are likely to commit a serious crime. Your provider will share the information with the appropriate law enforcement agency.

Unless you have been declared incompetent by a court of law, and have a legal guardian appointed to you, you 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 your treatment plan. Members are free to exercise these rights and that exercising these rights shall not adversely affect the way Trillium or providers treat the member.

IF I AM A MINOR, DO I HAVE ANY RIGHTS?

If you are under the age of 18, you 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.

You also can 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

WHAT ARE MY RESPONSIBILITIES?

In addition to your rights as a member of the Trillium Health Plan, you can ensure the best outcomes for yourself by assuming the following responsibilities:

- Seeking help when you need it and calling your provider or Trillium if you are in crisis
- Supplying all information (to the extent possible), including information about your health problems, that Trillium and its providers need in order to provide care for you
- Following the plans and instructions for care that you have agreed to with your providers
- Understanding your health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible, telling the doctor, nurse or other service provider about any changes in your health and asking questions when you do not understand your care or what you are expected to do
- Inviting people who will be helpful and supportive to you to be included in your treatment planning
- Working on the goals of your Person-Centered Plan
- Respecting the rights and property of other individuals, and of Trillium and provider staff
- Respecting the privacy and security of other individuals.
- Keeping all the scheduled appointments and being on time for appointments
- Canceling an appointment at least 24 hours in advance if you are unable to keep it
- Meeting financial obligations according to your established agreement
- Informing staff of any medical condition that is contagious
- Taking medications as they are prescribed for you
- Telling your doctor if you are having unpleasant side effects from your medications or if your medications do not seem to be working to help you feel better
- Refrain from "doctor shopping" in an attempt to obtain more prescriptions than you need
- Telling your doctor or therapist if you do not agree with their recommendations
- Telling your doctor or therapist if and when you want to end treatment
- Carrying your Medicaid or other insurance card with you at all times, and not allowing friends, family members or others to use your Medicaid card
- Cooperating with those trying to help you
- Following the rules posted in day, evening or 24-hour service programs
- Being considerate of other individuals and family members
- Seeking out additional support services in your community
- Reading, or having read to you, written notices from Trillium about changes in benefits, services or providers
- When you leave a program, requesting a discharge plan, being sure you understand it and being committed to following it

WHAT ARE MY RIGHTS IN A 24-HOUR FACILITY OR ADULT CARE HOME?

If you receive care in a 24-hour facility or adult care home, you have the rights listed on the previous page.

You also have the right to:

- Receive necessary medical care if you are sick. If your insurance does not cover the cost, then you 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. Your 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, your own doctor, or other private professionals. This will be at your own expense, not at the expense of the facility.
- Contact and consult with your parent or legal guardian at any time, if you are under 18 years of age.
- Make and receive confidential telephone calls. All long distance calls will be at your expense, not at the expense of the facility.
- Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. Visiting hours must be available six hours each day. Two of those hours must be after 6 p.m. If you 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 you. This may be under supervision if your treatment team feels this is necessary.
- Make visits outside the facility, unless it has been included in your 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 your private belongings that can be locked and only accessible by you, 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 your own money; if the facility is holding your money for you, you can examine the account at any time.
- Participate in religious worship if you choose.
- Retain a driver's license, unless you 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, yours or another's welfare, nonpayment, or if mandated by State or federal law. You must be given 30 days' of notice except in case of safety to yourself or others. You can appeal a transfer or discharge (according to rules by the Medical Care Commission), and you can stay in the facility until resolution of the appeal.

Each client 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; and
- Provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to tooth-paste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.
- Access to bathtubs or showers and toilets which ensure individual privacy shall be available.
- Access to adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.
- Atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; andaccessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.
- Ability to suitably decorate their room, or their 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.

WHAT ARE MY RIGHTS IF I HAVE AN INTELLECTUAL/DEVELOPMENTAL DISABILITY?

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

WHAT ARE RESTRICTED RIGHTS?

Your rights can only be restricted for reasons related to your care or treatment by your treatment team. You must be part of your treatment team and the decision-making process. You have the right to have an advocate or someone you trust involved. A restriction of your rights must go through a Human Rights Committee for approval. Any restriction will be documented and kept in your medical record.

WHAT DO I DO IF I BELIEVE MY RIGHTS HAVE BEEN VIOLATED?

If your rights have been violated, contact the Member and Recipient Service Line at 1-877-685-2415. You can file a complaint or grievance in person or by phone. You do not have to give your name. If you feel your protected health information has been violated, you may file a complaint or grievance with Trillium by calling 1-877-685-2415.

You may also contact the:

N.C. Division of Medical Assistance
Privacy Official

2501 Mail Service Center

Raleigh, NC 27699-2501

Phone: 919-855-4100

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

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 your information to
919-715-7724

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, sexual orientation or gender identity. If you feel your civil rights have been violated, please see instructions on **page 4** of this handbook.

WHAT IS INFORMED CONSENT?

You 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.

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

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

WHAT IF I AM UNABLE TO MAKE A DECISION ABOUT MY CARE?

You have the right to make instructions for your treatment in advance. There are three types of advance directives. These legal documents allow you to let your wishes be known in the event you are unable to make decisions for yourself.

These are:

- Psychiatric Advance Directives or the Advance Directive for Mental Health Care
- Health Care Power of Attorney
- Living will

Psychiatric Advance Directives

The Psychiatric Advance Directive (PAD), available at medicaid.ncdhhs.gov/documents/advanced-directives, or the Advance Directive for Mental Health Care is a legal document that states the instructions for mental health treatment you would want to receive if you are in a crisis and unable to make decisions for yourself. Your service provider or care manager should be able to assist you in the development of this document.

The instructions give information about:

- What you think helps calm you
- How you feel about seclusion or electroconvulsive therapy
- What medicines you do not want to take
- Which doctor you want to be in charge of your treatment

These are decisions you can make in advance of any situation in which you are unable to communicate your wishes about your care and provide specific instructions to be followed by a physician or psychologist. The instructions you include in the PAD will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Your instructions may be overridden if you are being held in accordance with civil commitment law.

If your provider does not agree with any parts of the advance directive (due to a "matter of conscience" or personal objection), they must provide (in writing) why they disagree, include detail from the law that allows the objections, and describe the medical conditions involved. You may choose to see a new provider. Your instructions may also not be followed if you are being held in accordance with civil commitment law.

Health Care Power of Attorney

A Health Care Power of Attorney allows you to designate someone who can make decisions for you if you are unable to make your own choices about treatment. This document gives the person you designate as your healthcare agent broad powers to make healthcare decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment and other healthcare decisions with your healthcare agent.

Except to the extent that you express specific limitations or restrictions in this form, your healthcare agent may make any healthcare decision you could make yourself.

Living Will

A living will is a document that tells others what kind of care you want or if you want to die a natural death if you are incurably sick and cannot receive nutrition or breathe on your own.

All three of these documents must be written and signed by you while you are able to understand your condition and treatment choices and are able to make your wishes known. Two qualified people must witness all three types of advance directives. The living will and the Health Care Power of Attorney must be notarized.

What do I do with my Advance Directives?

Be sure to keep a copy in a safe place and give copies to your family, your treatment team, your doctor and the hospital where you are likely to receive treatment. You can also have your advance directive filed in a national database or registered with the N.C. Advanced Health Care Directive Registry, which is part of the Department of the North Carolina Secretary of State. There is a $10 fee to register. This includes the registration, a revocation form, registration card and password. You can use the revocation form at any time if you change your mind and your directives.

How long do my Advance Directives stay active?

Your advance directives are active until you cancel them. You may cancel or change your advance directives at any time unless you have been declared incompetent. If you cancel or change your advance directives, be sure to communicate the change to anyone who has a copy.

DO I LOSE MY RIGHTS IF I HAVE A GUARDIAN?

People who do not have the ability to make and communicate important decisions about their personal and financial affairs may be declared incompetent by a court and assigned a guardian to help them exercise their rights. If you have been adjudicated incompetent, your guardian is legally appointed by the court to serve as your decision-maker and advocate. However, your guardian must give you the opportunity to take part as fully as possible in all decisions affecting your life.

People who are adjudicated (determined) incompetent and who are assigned a court-appointed guardian retain all legal and civil rights, except rights granted to the guardian by the court. You should read the guardianship order carefully. Often it includes language that reserves some of your rights, such as your right to associate with your own friends, make decisions about where you live or make healthcare decisions.

CAN I HAVE MY COMPETENCY RESTORED?

If you have been declared incompetent, you can have your guardianship reversed and possibly be restored to competency (decision by a judge about your legal ability to make choices). You, the guardian or any other interested person can ask the clerk of Superior Court to re-open the case.

The request begins by filing a written motion or petition with the clerk in the county where the guardianship is administered.

To be restored to competency, you must prove that you are able to manage your own affairs and make and communicate important decisions. If competency is restored, the guardian is dismissed. Partial restoration of some rights is also an option. For more information about guardianship, please contact your local Department of Social Services (DSS) office or visit rethinkingguardianshipnc.org/ and www.ncdhhs.gov/assistance/guardianship/guardianship-alternatives-to-guardianship.

WHAT ARE MY PRIVACY RIGHTS?

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of Trillium's Notice of Privacy Practices
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Do you have certain rights when it comes to your health information?

Get a copy of your health and claims records	You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within **30 days** of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within **60 days**.
Request confidential communications	You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	You can ask for a list ("accounting") of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one "accounting" a year for free but will charge a reasonable, cost-based fee if you ask for another one within **12 months**.
Get a copy of our privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint or grievance if you feel your rights are violated	You can complain if you feel we have violated your rights by contacting us at 1-877-685-2415. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Can you tell us your choices about what we share for certain health situations?

In these cases, you have both the right and choice to tell us to:	Share information with your family, close friends, or others involved in payment for your care. Share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:	Marketing purposes Sale of your information (Trillium will **never** sell information about members)

How do we typically use or share your health information?

Help manage the health care treatment you receive	We can use your health information and share it with professionals who are treating you, unless this information could potentially harm you.	**Example**: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.	**Example**: We use health information about you to develop better services for you.
Pay for your health services	We can use and disclose your health information as we pay for your health services.	**Example**: We share information about you with your doctor to coordinate payment for your treatment.

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: Preventing disease Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse, neglect, or domestic violence Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: For workers' compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order or in response to a subpoena.

What are our responsibilities?

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

What organizations does this notice of privacy practices apply to?

This Notice of Privacy Practices applies to Trillium Health Resources only. Providers in Trillium Health Resources' network of providers are required to have their own Notice of Privacy Practices.

ARE THERE ANY RIGHTS THAT PROTECT ME IF I GO TO JAIL?

North Carolina correctional facilities must have a medical plan that includes policies for health screening of inmates upon admission, as well as administering, dispensing and controlling prescription and non-prescription medications. Jails must provide conferences with qualified medical personnel and privacy during examinations. You will be observed twice per hour, or four times per hour if you have a record of making suicide attempts or are displaying erratic behavior.

HOW DO I MAKE AN APPEAL OR FILE A GRIEVANCE?

In this section:

- What is an appeal?
- How do I file an appeal of an adverse benefit determination?
- What is a reconsideration request?
  - Can I receive services during my reconsideration review?
  - Can my reconsideration review request be expedited?
  - Can the reconsideration review timeframe be extended?
  - What if I disagree with the decision?
  - How do I file a formal appeal with the Office of Administrative Hearings?
  - Who is responsible for my services while my appeal is pending?
  - Can I appeal a decision about non-Medicaid services?
  - Can my reconsideration review request be expedited?
  - What if I disagree with the decision?
- What is a grievance?
- How do I file a grievance?
- What is the grievance process?
  - What if I'm not satisfied with the response to my Medicaid grievance?
  - What if I'm not satisfied with the response to my non-Medicaid grievance?
  - What records should I keep?
  - Can I get legal assistance?
- How can I file a complaint?
  - What does Trillium do when it receives a complaint?
  - What if I'm not satisfied with the response to my complaint?
- Add What if I am moved to the Standard Plan from Trillium?

We want you to understand your rights to request appeals and file grievances. Medicaid beneficiaries have a constitutional right to due process. Due process means you are entitled to a written notice and an opportunity to be heard. Our Medicaid appeals system is based on this fundamental right to due process.

Appeal:
An appeal means a request for review of an adverse benefit determination such as denial of services, reduction of services, or denying payment for services.

Complaint:
A complaint is any expression of dissatisfaction about Trillium or a network provider, submitted by anyone. Unlike a grievance, you do not need to have consent to file a complaint on anyone's behalf.

Grievance:
A grievance is any expression(s) of dissatisfaction about any matter other than an adverse benefit determination filed by a member or by an individual who has been authorized in writing to file on behalf of a member.

WHAT IS AN APPEAL?

An appeal means "a request for review of an adverse benefit determination."

An adverse benefit determination is when Trillium:

- Denies or partially denies a request for services for you
- Reduces, suspends (pauses) or terminates (ends) authorization for a service you are currently authorized to receive
- Denies the whole payment or partial payment of your authorized services. 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
- Fails to ensure that you receive services in a timely manner, as defined by the state
- Denies your request to dispute a financial liability (or responsibility), including cost sharing, copayments, premiums, deductibles, coinsurance and other financial liabilities
- Fails to allow you to get services outside the network, **but only if you live in a rural area and there is no network provider available to provide the service or situations listed in § 438.52(b)(2)(ii)**

A Medicaid appeal can be filed by you, your guardian or a representative, including your in-network provider or your attorney, who has your written consent (or permission) to act on your behalf. Trillium ensures that punitive action (of any kind of punishment) is not taken against you or your representative who either requests or supports a member appeal. Before the adverse benefit determination is final, you will receive a letter explaining how to appeal the adverse benefit determination. In most cases, if you properly appeal the adverse benefit determination by following the instructions in the letter, your services will continue through the end of the original authorization period.

Trillium ensures members are not discouraged, coerced (forced) or misinformed (given wrong information) regarding the type, amount and duration (length) of services they may request. In addition, Trillium does not discourage, coerce (force) or misinform (give wrong information) to members about the right to appeal the denial, reduction or termination (stopping) of a service.

Note: If you appeal a denial of a request for a new service, Trillium will not continue to authorize the requested service during that appeal period.

If Trillium reduces, suspends (pauses) or terminates (ends) a current, unexpired service authorization, Trillium must notify you in writing at least **10 calendar days** before such adverse benefit determination. If Trillium denies a request for a new service, you will be notified in writing when the denial decision is made. You will be notified in writing of the process to appeal an adverse benefit determination in the adverse benefit determination letter. It is very important for you to follow all instructions given in the notices and letters you receive after Trillium makes an adverse benefit determination.

HOW DO I FILE AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION?

If you wish to appeal a Trillium adverse benefit determination, **you must first request a Trillium Reconsideration Review, either orally or in writing**. If you do not like the outcome of the Trillium Reconsideration Review, you can formally request a State Fair Hearing with the Office of Administrative Hearings (OAH). Instructions for submission are included below.

An Appeals Coordinator is available to help explain and complete your appeal documentation, if requested by you, your legal guardian or your authorized representative. We must provide you with reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing auxiliary (assistive) aids and services upon request, such as interpreter services and TTY/TTD capability. You can call the Administrative and Business Line at 1-866-998-2597 to speak with the Appeals Coordinator, ask for an interpreter, or request auxiliary aids.

What is a reconsideration request?

A Trillium Reconsideration Review is a local, independent review of Trillium's adverse benefit determination. When Trillium makes a decision regarding your services, you will receive an adverse benefit determination letter in the mail. Within **sixty (60) calendar days** of the mailing date of your adverse benefit determination letter, you, your guardian or you authorized representative may request a Trillium reconsideration by asking for one, either orally or in writing. Your written or oral (voiced) request will be on time if Trillium received the request within the **sixty (60) calendar day** deadline.

To request a reconsideration, you must submit your request to any of the following:

By Fax	*1-252-215-6879*
By mail or in person	*Trillium Health Resources* *Attention: Appeals Coordinator* *201 West First Street* *Greenville, NC 27858*
By Phone	*1-866-998-2597*

Please remember that your representative must have your written consent to submit a reconsideration review request. We will send you a written acknowledgment when we receive your request. If you have submitted a request and have not received the acknowledgment, call us and let us know. We will not accept or process requests for reconsideration filed outside the timeline.

A healthcare professional with appropriate clinical expertise in treating your condition who was not involved in the original decision will decide your reconsideration review request. It can take up to **thirty (30) calendar days** to make a decision about your Trillium reconsideration review request.

Ombudsman Program

The NC Medicaid Ombudsman Program can help you through the appeals, grievance, and reconsideration processes. They can answer questions or help explain the steps involved. You can call them at 1-877-201-3750; info@ncmedicaidombudsman.org or visit www.ncmedicaidombudsman.org. Please note the Ombudsman Program does not take the place of Trillium's process for filing an appeal.

What records should I keep?

It is important for you to keep good records of written correspondence and telephone conversations. Keep every letter you receive from Trillium, your providers, or the Division of Health Benefits. On a sheet of paper, make a telephone log sheet.

Always write down:

- The date and number you called
- The name of the person with whom you spoke
- A note about the subject of the call
- When you can expect a response and from whom, or the name and number of another person for you to contact

Store your telephone log sheet and letters in a safe place. If you want a copy of your case file, free of charge, please contact Trillium and ask to speak to an Appeals Coordinator at 1-866-998-2597. Please let us know as soon as possible if you want a copy. The case file will include all records considered by Trillium in connection with the decision, including documents submitted by your provider. You can also submit new information during the appeal process. This might include new information from your physician, such as updated assessments.

All appeal records are kept by Trillium for a minimum of **ten years** after resolution. There must be no future litigation or audits for these records to be destroyed.

Can I receive services during my reconsideration review?

Federal law allows you to continue receiving services when you appeal an adverse benefit determination. If you wish for existing services to continue without interruption until the end of the original authorization period while you appeal a Medicaid reduction, suspension (pause), termination (end) or denial, **you must request the Trillium reconsideration review within ten (10) calendar days from the date the adverse benefit determination letter was mailed**.

If you request a reconsideration review **eleven (11) to sixty (60) calendar days** from the date the adverse benefit determination letter was mailed, there could be an interruption in your current services. Upon receipt of your Reconsideration Review Request Form, we will reinstate the services if requested to do so.

Federal law explains this in much more detail. It says that if Trillium terminates, suspends or reduces your current Medicaid services before the expiration of the authorization period, you may continue to receive those Medicaid services if you meet all of the following conditions:

- You timely submit a Reconsideration Review Request Form, meaning on or before the following (whichever is later):
  - Within **ten (10) calendar days** of Trillium mailing the adverse benefit determination; or
  - The intended effective date of Trillium's proposed adverse benefit determination;
- The reconsideration review involves the termination, suspension or reduction of currently authorized services;
- The services were ordered by an authorized provider;
- The authorization period for the services has not expired; and
- You timely request (within **ten (10) calendar days**) that your services continue.

If all of these conditions are met, you may continue to receive your current services until:

- You withdraw your request for a reconsideration review or State Fair Hearing;
- **Ten calendar days** after Trillium mails the reconsideration review decision to you, unless you request a State Fair Hearing with the N.C. Office of Administrative Hearings (OAH) within those **ten (10) calendar days**;
- A State Fair Hearing office issues a hearing decision against you; or
- The authorization period for the services expires or authorization service limits are met.

By mail or in person:
Trillium Health Resources
Attention: Appeals Coordinator
201 West First Street
Greenville, NC 27858

Can my reconsideration review request be expedited?

You may request to expedite (speed up) the reconsideration process if the **thirty (30)-day** timeframe will harm your health and safety. You can request an expedited reconsideration by asking for one, either orally or in writing. If you make an oral request, it does not have to be followed up with a written request . We will approve or deny your request to expedite your reconsideration review request. If we deny your request for an expedited appeal, you may file a grievance about our decision to deny your request.

If you request an expedited reconsideration and Trillium denies it, we will notify you by telephone of the decision NOT to expedite the request. You will be notified in writing of Trillium's decision to expedite your request within **two (2) calendar days.** When denied, the reconsideration will be processed within standard timeframes of **thirty (30) calendar days**. Trillium reconsideration requests that are approved as expedited will be processed within expedited timeframes of **seventy-two (72) hours** from time of receipt of the request.

Can the reconsideration review timeframe be extended?

Trillium may extend the timeframes up to **fourteen (14) calendar days** if you request an extension. Trillium may extend timeframes up to **fourteen (14) calendar days** on its own when there is a need for additional information and the extension is in your interest.

When Trillium extends timeframes, but you did not request the extension, Trillium will:

- Provide you with written notice of the reason for the extension within **two business days**
- Make an effort to provide prompt verbal (by telephone) notification of the delay
- Resolve the appeal as quickly as your health condition requires and no later than the date the extension expires
- Inform you of your right to file a grievance regarding the extension

What if I disagree with the decision?

If you do not agree with the outcome of the reconsideration, you can file a formal appeal with the N.C. Office of Administrative Hearings (OAH) to request a State Fair Hearing. The request for State Fair Hearing must be made to OAH within **120 calendar days** of the mailing date of the reconsideration review decision (called the Notice of Resolution letter). Formal appeals are heard by an administrative law judge with OAH. If you have questions, you may call DHHS's toll-free CARELINE Information and Referral Service at 1-800-662-7030 and ask for the DHB Hearing Office.

How do I file a formal appeal with the Office of Administrative Hearings?

If you wish to request a State Fair Hearing, please mail or fax the State Fair Hearing form you received from Trillium to the addresses or fax numbers listed below:

Agency	*Mailing Address*	*Telephone Number*	*Fax Number*
North Carolina Office of Administrative Hearings (OAH)	Attn: Clerk 6714 Mail Service Center Raleigh, NC 27699	1-984-236-1850	1-984-236-1871
Trillium Health Resources	Attn: Appeals Department 201 West First Street Greenville, NC 27858	1-866-685-2415	1-252-215-6879

After you request a State Fair Hearing, OAH or the Mediation Network of North Carolina will offer you the option to have your case mediated by a mediator over the phone. A mediation is an informal meeting to attempt to resolve a formal appeal before it is heard by the administrative law judge. If you accept mediation, it must be completed within **twenty-five (25) days** of your formal appeal submission. If you agree to mediation and fail to participate, OAH will dismiss your appeal and it will not proceed to a hearing. If you decline mediation, or you accept mediation and it is unsuccessful, your formal appeal will proceed to a hearing. You will be notified by mail of the date, time and location of the hearing.

During the mediation phase of the appeal, Trillium's Appeals Coordinator is available to provide assistance to explain and complete required appeal documentation if requested by you, your legal guardian or your authorized representative. If mediation resolves the case, the hearing will be dismissed. Services will be provided as agreed upon during the discussion with the Mediation Network of North Carolina.

You may represent yourself in the hearing process, hire an attorney or ask a relative, friend or other spokesperson to speak on your behalf. We will provide you with all documents we intend to use at the hearing in advance. You can present new evidence at the hearing, although this may result in a delay. At the hearing, both sides can present evidence.

If the formal appeal is not settled at mediation, the matter will be set for a hearing with an administrative law judge. The administrative law judge will make a decision regarding your case. You will receive a written copy of the administrative law judge's decision. Normally, the administrative law judge will issue a decision within **90 days** of the hearing date. If you disagree with the administrative law judge's final decision, you may retain an attorney and appeal your case in Superior Court.

Who is responsible for my services while my appeal is pending?

If the final decision is not in your favor (Trillium's reduction, suspension, termination, or denial is upheld), then Trillium may elect to recover from you the cost of the services furnished to you during the formal appeal process.

Can I appeal a decision about non-Medicaid services?

Unlike Medicaid services, State law makes clear that there is not an entitlement to non-Medicaid services, and the appeal rights are different. In general, you may request an appeal if Trillium issues a decision to deny, reduce, terminate or suspend a non-Medicaid service.

Trillium will notify you in writing within one day if we make a decision to deny, reduce, suspend or terminate your non-Medicaid services. If you get a letter from us saying some or all of your non-Medicaid services have been reduced, suspended, terminated or denied, you can appeal the decision.

This notice of decision will include an appeal form and information about how to file your Trillium appeal request and all subsequent appeals. You must file an appeal with Trillium before you file an appeal with the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

To appeal the reduction, suspension, termination or denial of non-Medicaid benefits, you must complete and return the Non-Medicaid Services Appeal Form (included in the notice of decision mailed to you) to any of the following **within 15 business days** of the date of your notice of decision. **Your provider cannot file the appeal for you.**

Send the form to:

By fax:	252-215-6879
By mail:	Trillium Health Resources Attn: Appeals Coordinator 201 West First Street Greenville, NC 27858

You will receive an acknowledgment letter within the **next business day** of Trillium's receipt of the Non-Medicaid Services Appeal Form. A Trillium appeal is an impartial review of the decision to reduce, suspend, terminate or deny your Non-Medicaid services. A healthcare professional with appropriate clinical expertise in treating your condition or disorder who was not involved in the original decision will issue the appeal. Trillium will decide your appeal within **seven business days** of receipt of a valid request. Services will not be authorized during the review.

Can my reconsideration review request be expedited?

You may request to expedite (speed up) the reconsideration process if the **seven-day** timeframe will harm your health and safety. You can request an expedited reconsideration by asking for one, either orally or in writing. If you make an oral request, it does not have to be followed up with a written request (unlike the actual request for reconsideration). We will approve or deny your request to expedite your Reconsideration Review Request.

By mail or in person:	Trillium Health Resources Attention: Appeals Coordinator 201 West First Street Greenville, NC 27858

If you request an expedited reconsideration, and Trillium denies it, we will notify you by telephone of the decision NOT to expedite the request. If we agree that it should be expedited, we will complete the expedited review within **72 hours** of the request and let you or your provider know our decision by phone. We will send you a written decision no more than **three days** after that.

What if I disagree with the decision?

If you disagree with the appeal decision, you may file an appeal with the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) to request a non-Medicaid appeal hearing within **11 calendar days** of the appeal decision letter date. To file an appeal with DMH/DD/SAS, you must mail or fax a completed Non-Medicaid Appeal Request Form to:

By mail:	DMH/DD/SAS Hearing Office c/o Customer Service and Community Rights Mail Service Center 3001 Raleigh, NC 27699-3001
By fax:	919-733-4962

The Non-Medicaid Appeal Request Form is included in the decision letter. Remember: DMH/DD/SAS must receive the request form no later than **11 days** from the date of the Trillium appeal decision letter. Appeals are heard by a DMH/DD/SAS hearing officer at a Trillium office location. If you have questions about the DMH appeal process, please call DMH/DD/SAS at 919-715-3197.

Upon receipt of an appeal request, DMH/DD/SAS will:

- Review the appeal to determine your eligibility to appeal
- Accept or deny the appeal. If the appeal is accepted, the office will contact you to schedule a non-Medicaid appeal hearing (with at least **15 days** notice)
- Request documentation from Trillium used in the initial decision and appeal

The non-Medicaid appeal hearing:

- Is conducted by a DMH/DD/SAS hearing officer
- Is conducted in person
- Is scheduled for two hours
- Is attended by the appellant (recipient who filed the appeal) and/or his or her representatives
- Is attended by one or more Trillium representatives

Within **60 days** of the written request for appeal, the Hearing Officer will issue a written decision that includes findings, decisions and recommendations to you or your legal representative and the Trillium Chief Executive Officer. Within **10 calendar days** of receipt of the hearing officer's findings, Trillium will issue and send a written final decision to you or your legal representative.

Trillium ensures recipients are not discouraged, coerced (forced) or misinformed (given wrong information) regarding the type, amount and duration (length) of services they may request. In addition, Trillium does not discourage, coerce (force) or misinform (give wrong information) to members about the right to appeal the denial, reduction, or termination (stopping) of a service.

WHAT IS A GRIEVANCE?

A grievance is defined as any expression(s) of dissatisfaction about any matter other than an adverse benefit determination (see definition below) filed by member/recipient or by an individual who has been authorized in writing to file on behalf of a member.

Your family members, friends, advocates and/or your attorney may also help you file a grievance. You or your network provider that has been authorized in writing to act on your behalf may file requests for grievances.

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 in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- The failure of an LME/MCO (such as Trillium) or Prepaid Inpatient Health Plan (PIHP) to act within the timeframes provided in § 438.408(b)
- The denial of a member's request to exercise his or her right, under § 438.52 (b) (2) (ii), to obtain services outside the network
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financials liabilities
- For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to exercise his or her right, under the Federal Regulations, to obtain services outside the network.

Examples of grievance matters are:

- Staff not keeping an appointment
- Staff not being respectful to you
- Quality of care with a provider
- Lack of access to services where you live or services that are not allowed on the benefit plan
- Attitude of Trillium staff and providers
- Billing and financial issues
- Quality of your practitioner's office site

HOW DO I FILE A GRIEVANCE?

If you are unhappy with your services, you have the right to file a grievance with Trillium. Members with Medicaid have a constitutional right to due process. Due process means you are entitled to a written notice and an opportunity to be heard.

You can file a grievance in any of the following waysways, either in writing, in person, over the phone, or electronically:

- By speaking to a Trillium representative through our Administrative and Business Line: 1-866-998-2597
- By completing an online submission form at www.trilliumhealthresources.org/explore-trillium/contact-us/complaint-grievance-compliment-question
- Through NC DHHS: Members can submit grievances directly to NC DHHS and they are forwarded to Trillium for follow up and resolution; we will update NC DHHS as needed.

DHHS ADA/RA Complaints

Office of Legal Affairs

2001 Mail Service Center

Raleigh, NC 27699-2001

- Any Trillium staff can enter a grievance or appeal on behalf of a member/recipient (with your permission). This supports our "no wrong door" policy by offering various ways for people to file grievances.
- In writing and mailed to:

Trillium Health Resources

Attn: Grievance Department

201 W. First St.

Greenville, NC 27858

If you want to discuss a grievance, you can contact Trillium on our Administrative and Business Line at 1-866-998-2597. You may also share your concerns with your provider or care manager directly and ask them to help or advise you. **You are not required to discuss your grievance directly with your provider before calling Trillium.** If you decide to file a grievance and need assistance, contact Trillium at **1-866-998-2597.**

When you call Trillium to discuss your grievance, we will make a written record of it. **If your grievance involves health and safety concerns, we will take action immediately.** You and/or your family member have the right to be represented and have support from advocates, personal supporters or a legally responsible person at any meeting held to discuss the grievance.

Your provider can assist you with filing a grievance as well. However, if the provider calls to file a grievance on your behalf, **the provider must have your written consent**.

WHAT IS THE GRIEVANCE PROCESS?

Once Trillium receives your grievance, we will:

- Make a written record of the grievance
- Send written acknowledgment of your grievance within one business day
- Contact you and others involved with the grievance to help resolve your concerns
- Consult the department that can best address your concerns. If your grievance involves health and safety concerns, we will take action immediately
- Attempt to mediate your grievance with your provider agency; you are not required to use your service provider's grievance process

We will discuss the resolution of the grievance with you and send you a formal resolution letter. The notification will specify if your grievance is referred to another agency, such as the state Division of Health Service Regulation (DHSR) (if a licensed facility is involved). You will not lose your Medicaid benefits or access to state-funded services for filing a grievance.

It is Trillium's policy that all grievances must be resolved within **thirty (30) calendar days**, not to exceed **ninety (90) calendar days** of receipt.

This timeframe can be extended by **14 calendar days** *if:*

1. You make the request.
2. Trillium demonstrates to the DHB that there is a need for additional information and the delay is in your best interest.

What if I'm not satisfied with the response to my Medicaid grievance?

You can appeal the resolution of grievances regarding Medicaid-funded services or other matters by calling our Administrative and Business Line at 1-866-998-2597. Grievance appeals must be requested within **sixty (60) calendar days** from the date of the Grievance Resolution Letter.

What if I'm not satisfied with the response to my non-Medicaid grievance?

You can appeal the resolution of grievances regarding non-Medicaid-funded services or other matters by calling our Administrative and Business Line at 1-866-998-2597. Trillium Health Resources must receive your Grievance Appeal Request within **sixty (60) calendar days** from the date on the Grievance Resolution Letter.

If you are not satisfied with the response you receive from Trillium, you may contact Disability Rights North Carolina at 1-877-235-4210. You may also call the Advocacy and Customer Service Section under Customer Service and Community Rights of the N.C. DMH/DD/SAS at 919-715-3197.

What records should I keep?

It is important for you to keep good records of written correspondence and telephone conversations. Keep every letter you receive from Trillium, your providers, or the DHB. On a sheet of paper, make a telephone log sheet.

Always write down:

- The date and number you called
- The name of the person with whom you spoke
- A note about the subject of the call
- When you can expect a response and from whom, or the name and number of another person for you to contact

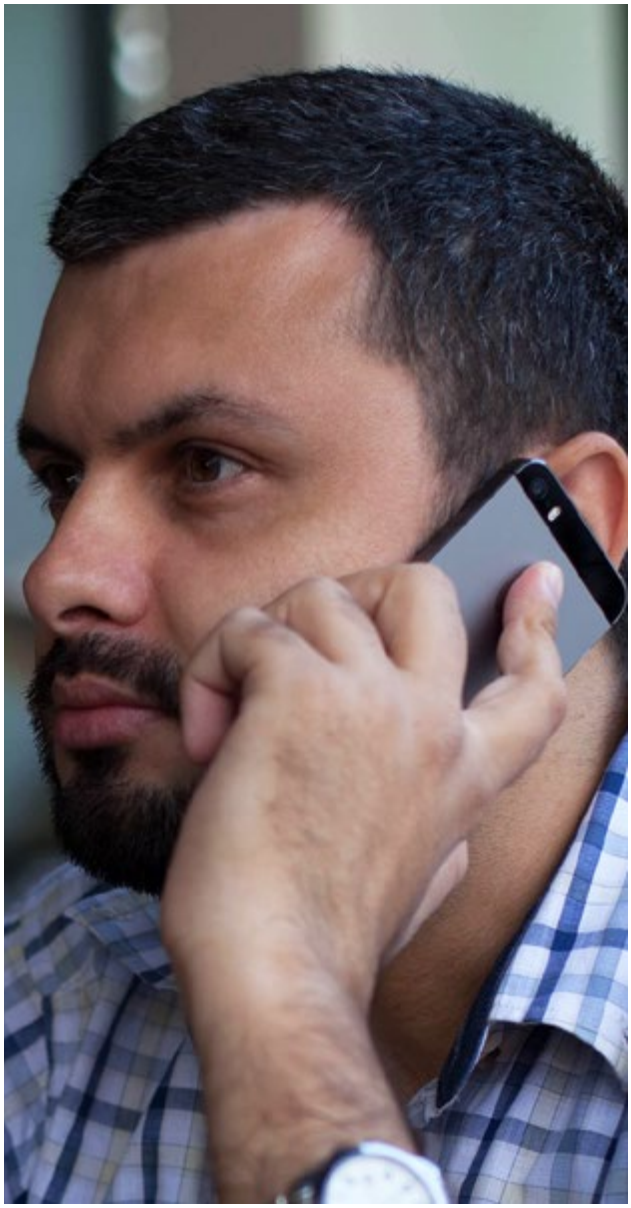
Store your telephone log sheet and letters in a safe place. All grievance records are kept by Trillium for a minimum of **ten years** after resolution. For these records to be destroyed, there must be no future litigation or audits that will occur.

Can I get legal assistance?

To locate a lawyer, please call 1-800-662-7660 for the N.C. Health Information Project Lawyer Referral Service or 1-800-662-7407 for the N.C. State Bar Lawyer Referral Service. You can also call Disability Rights of North Carolina toll-free at 1-877-235-4210 or Legal Aid of North Carolina at 1-866-219-5262.

HOW CAN I FILE A COMPLAINT?

Individuals also have the option to file complaints, which are different from grievances and appeals. A complaint is any expression of dissatisfaction about Trillium or a network provider, initiated by anyone who does not have written consent to file a grievance on a member or recipient's behalf.



Examples of complaints are:

- Staff tardiness
- Staff not being respectful to a member
- Quality of care or access to services
- Attitude of Trillium staff and providers
- Billing and financial issues
- Quality of a practitioner's office site

Friends, family members who are not guardians or coworkers may choose to file a complaint with Trillium and may file anonymously (without giving their name).

Anyone can file a complaint in person, in writing, electronically, or over the phone by:

- Speaking to a Trillium representative on our Administrative and Business Line: 1-866-998-2597
- Completing a form through the Trillium website at www.trilliumhealthresources.org/explore-trillium/contact-us/complaint-grievance-compliment-question
- Through NC DHHS: Members can submit grievances directly to NC DHHS and they are forwarded to Trillium for follow up and resolution; we will update NC DHHS as needed.

DHHS ADA/RA Complaints

Office of Legal Affairs

2001 Mail Service Center

Raleigh, NC 27699-2001

- Any Trillium staff can enter a grievance or appeal on behalf of a member/recipient. This supports our "no wrong door" policy by offering various ways for people to file grievances.
- Sending a written complaint. Written complaints should be mailed to:

Trillium Health Resources

Attn: Complaints Department

201 W. First St.

Greenville, NC 27858

If you want to discuss a complaint, you can contact Trillium's Administrative and Business Line at 1-866-998-2597. When anyone calls Trillium to discuss a complaint, we will make a written record of it. If the complaint involves health and safety concerns, Trillium will take action immediately. You and/or your family member have the right to be represented and have support from advocates, personal supporters or a legally responsible person at any meeting held to discuss the complaint.

What does Trillium do when it receives a complaint?

It is Trillium's policy that all complaints must be resolved within **30 calendar days** of receipt. This timeframe can be extended by **14 calendar days** if:

1. You make the request.
2. Trillium demonstrates to the DHB that there is a need for additional information and the delay is in your best interest.

Once Trillium receives your complaint, we will:

- Send written acknowledgment to the person who filed the complaint
- Contact you and others involved with the complaint to help resolve your concerns
- Attempt to mediate the complaint with your provider agency.
- Trillium will discuss the resolution of the complaint with you and send you a formal resolution letter

What if I am not satisfied with the response to my complaint?

All complaints have appeal rights, for both Medicaid and non-Medicaid services. Individuals must file an appeal to the complaint within **21 calendar days** from the date of receipt of the Complaint Resolution Letter. The resolution letter will include information on how to file this appeal.

A decision on the appeal will be mailed back to the complainant within **28 calendar days** from receipt of the appeal. This second decision is final, and there are no further appeal rights. All complaint records are kept by Trillium for a minimum of ten years after resolution. For these records to be destroyed, there must be no future litigation or audits that will occur.

WHAT IF I AM MOVED TO THE STANDARD PLAN FROM TRILLIUM?

Trillium works with NC DHHS to determine when members may no longer need the more extensive services available under Trillium's Plan. When this occurs, members are transferred to the Standard Plan. The Standard Plan serves most individuals receiving Medicaid services in North Carolina with some of the behavioral health services available on Trillium's Plan.

There are still many services available in the Standard Plan for mental health and substance use disorders, including:

- Individual and group therapy
- Facility-based crisis programs
- Mobile crisis management services
- Outpatient opioid treatment
- Alcohol and drug use treatment center detox crisis stabilization

If you feel you would be better served through Trillium, please call the Enrollment Broker at 1-833-870-5500, ask your provider to complete the proper paperwork, or speak with your care manager. Any open grievances or complaints will still be resolved by Trillium if a member is moved to the Standard Plan.

HOW CAN I HELP PREVENT FRAUD & ABUSE?

In this section:

- What is fraud and abuse?
- How can I help prevent fraud and abuse?
- How do I report fraud and abuse?

WHAT IS FRAUD AND ABUSE?

Trillium is committed to preventing and identifying fraud and abuse in the Medicaid program. You can help by reporting any suspicious billing practices or other activity you think may be fraud or abuse.

Medicaid fraud occurs when a healthcare provider submits a false or fraudulent claim or when a person intentionally lies or conceals income or assets to obtain government benefits. Abuse occurs when a person or healthcare provider engages in activities that result in unreasonable or excessive cost to the Medicaid program, including a Medicaid managed care organization, such as Trillium. The federal government estimates fraud and abuse costs U.S. taxpayers more than $15 billion every year.

Examples of fraud and abuse may include:

- You fail to report all your income or other insurance when applying for Medicaid.
- You let someone else use your Medicaid card to obtain services.
- Someone steals your Medicaid card and uses it without your permission.
- A provider bills Trillium for services or supplies that you never received.
- A provider bills Trillium for services that were not medically necessary, not coded properly or not supported by all required documentation.
- A provider's reported credentials are false.

HOW CAN I HELP PREVENT FRAUD AND ABUSE?

Are there specific things that I SHOULD do?

- DO protect your Medicaid number (on your Medicaid card) and your Social Security Number (on your Social Security card). Treat your Medicaid card like it is a credit card.
- DO ask for a copy of everything you sign and keep all paperwork together.
- DO ask questions. You have a right to know everything about your care and treatment, including costs billed to Trillium by your provider.
- DO use a calendar to record all of your service appointments and treatments. If you spend time in a hospital, make note of your admission date, discharge date and diagnosis.
- DO remain alert for services that were promised to you but never delivered or for unnecessary tests or procedures.
- DO be wary of providers who tell you that the item or service isn't usually covered, but they "know how to bill" so that Trillium or Medicaid will pay.
- DO remember that nothing is ever "free." Don't accept offers of money or gifts for free medical care.
- DO check your pills before you leave the pharmacy to be sure you got the correct medication, including whether it's a brand or generic and the full amount. If you don't get your full prescription, report the problem to the pharmacist.
- DO report suspected instances of fraud.

Are there specific things that I SHOULD NOT do?

- DON'T share your Medicaid card, Medicaid number, Social Security card, or Social Security Number with anyone except your doctor or other authorized provider.
- DON'T let friends, relatives or anyone else "borrow" your Medicaid card.
- DON'T ask your doctor or other health care provider for treatment or care that you do not need or let anyone else persuade you to see a doctor for care or services you don't need.
- DON'T accept gifts or kickbacks from your provider.
- DON'T share medical records or other sensitive information with anyone except Trillium or another insurance company, or a doctor, agency, clinic, hospital or other healthcare provider.
- DON'T accept medical supplies from a door-to-door sales representative. If someone comes to your door claiming to be from Medicare or Medicaid, remember that Medicare and Medicaid don't send representatives to your home to sell products or services.
- DON'T sign any blank forms.
- DON'T be influenced by certain media advertising about your health. Many internet, television, and radio ads don't have your best interest at heart.

HOW DO I REPORT FRAUD AND ABUSE?

You can remain anonymous, but detailed information will help us with our investigation. (In rare cases involving legal proceedings, Trillium may have to reveal who you are.) When you contact us, please provide the name/Medicaid ID number of the Medicaid beneficiary involved, the name of the provider, the date(s) of service, the amount of claims billed or paid and a description of the fraudulent or suspicious activity.

You can report suspected fraud and abuse in any of the following ways:

- Call Trillium's EthicsPoint toll-free, 24/7 hotline at 1-855-659-7660 (allows for anonymous reporting).
- Submit an online form by visiting www.TrilliumHealthResources.org and clicking "Report Fraud and Abuse" on the bottom of the page.
- Call the Medicaid Fraud, Waste and Program Abuse Tip Line at 1-877-DMA-TIP1 (1-877-362-8471).
- Call the N.C. Division of Health Benefits (DHB) Customer Service Center at 1-800-662-7030.
- Call the U.S. Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477).
- Call the N.C. State Auditor at 1-800-730-TIPS (1-800-730-8477).
- Submit a Medicaid fraud and abuse confidential (private) online complaint on the DHB Customer Service website: medicaid.ncdhhs.gov/meetings-and-notices/report-fraud-waste-or-abuse

ADVOCACY, RECOVERY AND RESILIENCE

In this section:

- How can Trillium help me in my recovery?
- What is resilience?
- What is the Consumer and Family Advisory Committee (CFAC)?
- What is the Human Rights Committee (HRC)?
- Does Trillium offer education or training?
- Does Trillium offer housing support programs?

HOW CAN TRILLIUM HELP ME IN MY RECOVERY?

Trillium believes that everyone is resilient and that people can recover from trauma. Everyone deserves to experience a fulfilling and productive life, and to reach their fullest potential. We want to help you identify your strengths and reach your goals. We can help you work with your family and your support system to participate more fully in the community of your choice.

We believe that recovery:

- Emerges from hope
- Is person-driven
- Occurs through many pathways
- Is holistic
- Is supported by peers and allies
- Is supported through relationships and social networks
- Is culturally-based and influenced
- Is supported by addressing trauma
- Involves individual, family and community strengths and responsibility
- Is based on respect

Each person's path to recovery is unique. 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.

Trillium strives to support you on your path to recovery by engaging in community collaboration and promoting services that improve the health and wellbeing of those we serve along with our communities. Our hope is that these programs will help you achieve your recovery goals and empower you to live in a healthy, safe and meaningful way.

WHAT IS RESILIENCE?

Resilience is the ability to adapt to stress. Resilience is the ability to withstand catastrophe. This means using coping skills to keep going in the face of adversity. Trillium can assist you with getting services and support to help with your situation. Contact Trillium at 1-877-685-2415 for assistance.

WHAT IS THE CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC)?

The Consumer and Family Advisory Committee (CFAC) consists of individuals who receive mental health, intellectual/developmental disability and substance use services and family members of those individuals. CFAC is a self-governing committee that serves as an advisor to Trillium administration and the Board of Directors. One CFAC member from each region also serves on the Governing Board.

State statutes charge CFAC with the following responsibilities:

- Review, comment on and monitor the implementation of the local business plan
- Identify service gaps and underserved populations
- Make recommendations regarding the service array and monitor the development of additional services
- Review and comment on the budget
- Participate in all quality improvement measures and performance indicators
- Submit findings and recommendations to the state CFAC regarding ways to improve the delivery of mental health, I/DD and substance use services

Please call 1-866-998-2597 for more information on involvement with CFAC, or visit www.trilliumhealthresources.org/regional-operations/regional-cfacs.

WHAT IS THE HUMAN RIGHTS COMMITTEE?

The Human Rights Committee (HRC) oversees Trillium's compliance with federal and state rules regarding individual rights, confidentiality and grievances. The HRC is made up of individuals, family members and board members who meet at least once quarterly. It reviews and monitors trends in the use of restrictive interventions, abuse, neglect and exploitation, deaths and medication errors. The HRC also makes reports to the Governing Board. Individuals, family members and other stakeholders may submit rights violations to the HRC or through the usual grievance process.

If you are interested in serving on the Human Rights Committee, you must be an adult member, family member, human service professional, or a Trillium Network Provider, and live in one of the counties in our catchment area. You can fill out a Human Rights Committee Application Form to be considered for membership, or if you have any questions call 1-866-998-2597.

DOES TRILLIUM OFFER EDUCATION OR TRAINING?

People who are well informed about their illnesses are better able to manage them and achieve desired results. Trillium provides educational opportunities to our members, families and other community members with helpful information about diagnoses, treatment options and maximizing treatment benefits. More information can be found on our website at www.trilliumhealthresources.org/news-events-training or by calling 1-877-685-2415.

Trillium provides links to Self-Management and Monitoring Tools on our website. Members can get information on a variety of topics such as but not limited to weight management, healthy eating, and managing stress. Our communities are only as strong as their people.

Trillium launched the **My Learning Campus** website to offer free, online trainings and tip sheets for our members. There is no cost to register and you can cancel at any time. Topics include updates to service offerings such as the Innovations Waiver, an introduction to Trillium, reducing stress, and more. Please visit www.MyLearningCampus.org for more information.

DOES TRILLIUM OFFER HOUSING SUPPORT PROGRAMS?

We believe having a safe and stable place to live is an integral part of wellbeing and recovery. There is no entitlement to housing funds through Trillium, other than Transitions to Community Living Initiative (TCLI). We work with community partners to provide knowledge, resources and training about housing and residential options. Please call 1-877-685-2415 for more information.

SUMMARY OF THE PROVISIONS OF THIS AGREEMENT TO BE PROVIDED TO MEMBERS AND PROVIDERS (INNOVATIONS WAIVER)

The following statements, which are directed to members and providers, supersede any information contained in this handbook which may be inconsistent with these statements.

- During the planning process, your Care Manager will explain the different services to you and work with you to develop your Individual Support Plan (ISP) based on the services you wish to request and goals you have chosen. Your Care Manager will also explain the requirements in the Innovations Waiver around those services.
- Your Care Manager will assure that your ISP will include the services that you want to request, for the length of time that you want to request them. Your ISP should be used to plan for the entire year, and services that you expect to need at any point during that year.
- You must have a signed ISP in order to receive services through the Innovations Waiver. That means that you need to sign the ISP containing the services that you want to request, which may be different than the services that will be approved. Your Care Manager will draft the ISP based on your wishes, will review the plan with you before you sign it, will answer any questions you have, and will make any changes to the ISP that you request before you are asked to sign it.
- If you wish to change or add services during the plan year, you may ask your Care Manager to help you request the change by writing an Update/ Revision to your ISP at any time.
- Resource Allocation/Individual Budgets and the Support Intensities Scale ® (SIS ®) are tools that may be used in the planning process. You may have an assigned Individual Budget, which is not a limit on the amount of services you can request or have approved. If any of the services that you requested are denied, you will receive written notice with information about how you can appeal that decision.
- During the planning process, your Care Manager will review your Individual Budget with you. As mentioned above, your Care Manager will assure that your ISP includes the services you want to request, for the length of time you want to request them.
- The Utilization Management Department of Trillium Health Resources will determine whether or not the services you request are medically necessary, not your Care Manager. A decision on your request for services in your ISP will be made within **14 days** unless more information is needed.
- If any service requested in your ISP is not fully approved (for example, a service is denied, or is approved for fewer hours or for a length of time that is less than what you requested), you will receive a written explanation of that decision and information about how you can appeal.
- Trillium will not retaliate against you in any way if you appeal. Your Care Manager can assist you with the forms needed to file an appeal.
- If some services are approved and some are denied, you can receive the services that were approved while you appeal the services that were denied. You may also make a new request for different services while your appeal is pending, if you wish to do so.

GLOSSARY OF WORDS AND TERMS TO KNOW

Advance directive: A communication given by a competent adult that gives directions or appoints another individual to make decisions concerning an individual's care, custody or medical treatment in the event that the individual is unable to participate in medical treatment decisions.

Ability-to-pay determination: The amount an individual is obligated to pay for services. The ability to pay is calculated based on the individual's income and number of dependents. The Federal Government Poverty Guidelines are used to determine the individual's payment amount. See more at www.medicaid.gov/medicaid/eligibility/index.html

Abuse and waste: Incidents or practices that are inconsistent with sound fiscal, business or medical practices that could result in an unnecessary cost to Trillium, the state or federal government or another organization. It could also result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)

Appeal: A request for review of an action.

Assessment: A procedure for determining the nature and extent of need for which the individual is seeking services.

Authorized service: Medically necessary services pre-approved by Trillium.

Best practices: Recommended practices, including evidenced-based practices that consist of those clinical and administrative practices, that have been proved to consistently produce specific, intended results, as well as emerging practices for which there is preliminary evidence of effectiveness of treatment.

Basic benefit plan: The basic benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services are intended to provide brief interventions for individuals with acute needs. The basic benefit package is accessed through a simple referral from the MCO through its screening, triage and referral system. Once the referral is made, there are no prior authorization requirements for these services.

Care Management Department: Care management is monitoring of an individual's care and services, including follow-up activities, as well as, assistance to individuals in accessing care on non-plan services, including referrals to providers and other community agencies.

Consumer and Family Advisory Committee (CFAC): A formalized group of individuals and family members appointed in accordance with the requirements of NCGS 122-C-170. The purpose of CFAC is to ensure meaningful participation by individuals and families in shaping the development and delivery of public mental health, I/DD and substance abuse services in the 27-county region serviced by Trillium.

Covered services: The service which Trillium agrees to provide or arranges to provide to members.

Cultural competency: The understanding of the social, linguistic, ethnic and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Centers for Medicare and Medicaid Services (CMMS or CMS): The unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

Complaint: A complaint is any expression of dissatisfaction about Trillium or a network provider, initiated by anyone who does not have written consent to file a grievance on a member's behalf.

County Department of Social Services (DSS): The local (county) public agency that is responsible for determining eligibility for Medicaid benefits and for other assistance programs.

Denial of service: A determination made by Trillium in response to a network provider's request for approval to provide in-plan services of a specific duration and scope that disapproves the request completely or approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; (an approval of a requested services that includes a requirement for a concurrent review by Trillium during the authorized period does not constitute a denial); or disapproves provision of the requested service(s) but approves provision of an alternative service(s).

Division of Health Benefits (DHB): The state agency responsible for Medicaid-funded services and the administration of the N.C. Innovations and N.C. MH/DD/SAS Health Plan. The website for North Carolina's Division of Health Benefits is medicaid.ncdhhs.gov.

Department of Health and Human Services (DHHS): The state agency that includes both the Division of Health Benefits and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS). The website for North Carolina's DHHS is www.ncdhhs.gov/.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS): The state agency that works with DHB in the administration of the N.C. Innovations and N.C. MH/DD/SAS Health Plan. The website for North Carolina's DMH/DD/SAS is www.ncdhhs.gov/mhddsas/.

Durable medical equipment: Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness, injury, or disabilty that requires it.

Enhanced benefit plan: A plan that includes services made available to Medicaid-entitled individuals and non-Medicaid individuals meeting priority population criteria. Enhanced benefit services are accessed through a person-centered planning process. Enhanced benefit services are intended to provide a range of services and supports that are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance use and with more complex service and support needs as identified in the person-centered planning process.

Early and Periodic Screening, Diagnosis and Treatment: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal Medicaid benefit that says Medicaid must provide all necessary healthcare services to Medicaid-eligible children under 21 years of age. Even if the service is not covered under the N.C. Medicaid State Plan, it can be covered for recipients younger than 21 if the service is listed at 1905(a) of the Social Security Act and if all EPSDT criteria are met.

Enteral Formula: Balanced nutrition especially designed for tube-feeding of children.

Formulary: an official list giving details of medicines that may be prescribed.

Grievance: A grievance is any expression(s) of dissatisfaction about any matter other than an adverse benefit determination filed by a member or by an individual who has been authorized in writing to file on behalf of a member.

Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.

Health Insurance Portability and Accountability Act (HIPAA): Law that provides standards to protect members' health information

Individual/member/enrollee/consumer: Different names used to describe a person who receives services coordinated by Trillium for treatment of a mental health, intellectual/developmental disability or substance use condition.

Integrated care: Focus on coordinated health care for the diagnosis, treatment, care, and services for an individual.

Least restrictive environment: The least restrictive/intensive setting of care sufficient to effectively and safely support an individual. Supporting an individual in the environment that is least restrictive is considered best practice.

Legal guardian or legally responsible person (LRP): A person who has been appointed by a court of law to act as decisionmaker for an individual deemed unable to make decisions on their own behalf. Parents of children younger than 18 are their children's legally responsible person unless those rights have been taken away by the court. Once a person turns 18, they legally become their own guardian unless the court deems otherwise and appoints a guardian representative (most often a family member or friend unless there is no one available, in which case a public employee is appointed).

Long-Term Services and Supports: A set of services to help individuals with certain health conditions or disabilities with day-to-day activities (like eating, bathing, or getting dressed).

Medical record: A single complete record, maintained by the provider of services, which documents all of the treatment plans developed for and behavioral health services received by the member.

Medically necessary services: Procedures or interventions that are appropriate and necessary for the diagnosis, treatment or support in response to an assessment of an individual's condition or need. Medically necessary means services and supplies that are provided for the diagnosis, secondary or tertiary prevention, amelioration, intervention, rehabilitation or care and treatment of a mental health, I/DD or substance use condition. The services must be within generally accepted standards of medical practice and not primarily for the convenience of an individual, and the services must be performed in the least costly setting and manner appropriate to treat the individual's mental health, I/DD or substance use condition.

Mediation: The process of bringing individuals or agencies in conflict together with a neutral third person who helps them reach a mutually agreeable solution.

Medicaid Direct: Previously known as Medicaid Fee-for-Service, this category of care includes those who are not part of Medicaid Managed Care.

Medicare: Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities and any age with end-stage renal disease (also known as ESRD/permanent kidney failure requiring dialysis or a kidney transplant).

Member: Individual who receives services through Medicaid.

Most integrated environment: The least restrictive setting of care sufficient to effectively treat or support a participant. An integrated environment is one in which a person with a disability participates in the same activities and settings as peers without disabilities.

N.C. Health Choice: N.C. Health Choice offers health insurance coverage for children ages 6 through 18 years old when their families do not qualify for Medicaid. Medicaid and N.C. Health Choice insurance are different; benefits vary including EPSDT.

N.C. Innovations: A 1915(c) Home and Community-Based Wavier for individuals with intellectual and/or developmental disabilities (I/DD). This is a waiver of institutional level of care.

N.C. MH/DD/SAS Health Plan: A 1915(b) Medicaid Managed Care Waiver for Mental Health and Substance Abuse allowing for a waiver of freedom of choice of providers so that Trillium can determine the size and scope of the provider network. This also allows for use of Medicaid funds for alternative services.

Natural supports: People who provide support, care and assistance to a person without payment for that support. Natural supports may include parents, siblings, extended family members, neighbors, church members and/or co-workers, etc.

Neighborhood Connections: A unit within Trillium that works with member and their families to connect them to available resources that address unmet health related resource needs.

Network provider: An appropriately credentialed provider of mental health, I/DD and substance use services that has entered into a contract for participation in the Trillium network.

Out-of-plan services: Healthcare services that the plan is not required to provide under the terms of this contract. The services are Medicaid-covered services reimbursed on a fee-for-service basis.

Out-of-network provider: A practice or agency who has been approved as an out-of-network provider and has executed a single-case agreement with Trillium. The out-of-network provider is not offered as a choice of referral to Trillium members.

Palliative Care: Specialized care for a patient and family that begins at diagnosis and treatment of a serious or terminal illness.

Postnatal: Pregnancy health care for a mother who has just given birth to a child.

Person-Centered Plan (PCP): The document that includes important information about the participant, his or her life goals and the steps that he or she and the planning team need to take to get there. It also identifies service or support needs and includes a combination of paid supports, natural supports from family and friends and community supports.

Prenatal: Pregnancy health care for expectant mothers, prior to the birth of a child.

Prepaid Inpatient Health Plan (PIHP): Trillium, as do all N.C. managed care organizations (MCOs), functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, I/DD and substance services are managed and authorized for Medicaid participants in Trillium's 28 counties.

Primary Care: The day-to-day health care given by a health care provider, to include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings.

Primary Care Provider (PCP): The provider who takes care of and coordinates all your physical health needs. Your PCP is often the first person you should contact if you need care. Your PCP is your doctor, clinic, of other health care provider.

Provider network: The agencies or professionals under contract with Trillium to provide authorized services to eligible individuals.

Rehabilitation and Therapy Services: Health care services that help you recover from an illness, accident, injury, or surgery. These services can include physical or speech therapy.

Risk Support Needs Assessment: An assessment of factors that, if unaddressed, might pose a high threat to an individual's health and welfare. These include: health risk (medical conditions that require continuing care and treatment); behavioral risk (behaviors or conditions that might cause harm to the person or others); and personal safety risk, (e. g., ability to make safe evacuation independently).

Recipient: Individual who receives State-funded services.

Reconsideration review: A review of a previous finding or decision by Trillium based on the provider's reconsideration request and any additional materials presented by the provider.

Specialty Care: A unit within Trillium that works with members and their families to obtain medically necessary assistive technology, home and vehicle modifications using innovations waiver funding.

Spend-down: Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time.

Standard Plan: Name given to the NC Medicaid Managed Care plan that will provide integrated physical health, behavioral health, and pharmaceutical services to the majority of members receiving Medicaid services.

State plan: The term that refers to the state Medicaid Plan for Medicaid for the State of North Carolina that is approved by the Center for Medicare & Medicaid Services (CMS).

Supplemental Security Income (SSI): Social Security program that pays benefits to adults and children with disabilities who have limited income and resources.

Support services: Services that enable an individual to live in his or her community. These include services that can provide direct assistance to the individual and/or services that provide assistance to the individual's caregivers and/or support staff.

Tailored Plan: Name given to the NC Medicaid Managed Care plan that will serve individuals with significant behavioral health needs, intellectual/developmental disabilities (I/DD), and traumatic brain injury (TBI).

Telemedicine: The practice of caring for patients remotely when the provider and patient are not physically in the same room. It is usually accomplished using a HIPAA-compliant videoconferencing tools.

Utilization Management Department (UM): The UM department is responsible for approving Individual Support Plans and authorizing medically necessary services.

Whole Person Care: Coordination of physical health, behavioral health, and social services in a person-centered manner.

ACRONYMS

ACTT	Assertive Community Treatment Team
ASAM	American Society of Addiction Medicine
CALOCUS©	Child and Adolescence Level of Care Utilization System
CBT	Cognitive Behavioral Therapy
CFAC	Consumer and Family Advisory Committe
CST	Community Support Team
DHB	Division of Health Benefits
DHHS	Department of Health and Human Services
DMH/DD/SAS	Division Mental Health/Developmental Disabilities/Substance Abuse Services
DOC	Department of Corrections
DSS	Department of Social Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for individuals with intellectual disabilities
I/DD	Intellectual and/or developmental disabilities
ISP	Individual Support Plan
LOCUS©	Level of Care Utilization System
LME/MCO	Local Management Entity/Managed Care Organization
MH	Mental health
MST	Multi-Systemic Therapy
NC-TOPPS	North Carolina Treatment Outcomes and Program Performance System
PAD	Psychiatric Advanced Directive
PCP	Person-Centered Plan
PHI	Protected health information
PSR	Psychosocial Rehabilitation
SOC	System of Care
SIS	Supports Intensity Scale
SSI	Supplemental Security Income
SU/SUD/SA	Substance use/substance use disorders/substance abuse
TBI	Traumatic brain injury
TCLI	Transitions to Community Living Initiative
UM	Utilization management
UR	Utilization review

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

For information about treatment services and supports near you,
call our Member & Recipient Service Line at:
1-877-685-2415 (Toll-free)

TTY: Dial **711** or **1-800-735-2962** and follow directions on screen

IN CASE OF A LIFE-THREATENING EMERGENCY,
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