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

ARTICLE I:
GENERAL TERMS AND CONDITIONS

1. **DEFINITIONS.** Any term defined by NCGS122C-3 shall have the same definition in this contract unless otherwise specified.
   A. "Amendment" shall mean as set forth in G.S. §58-50-270.
   B. "Allowable Charges" means Contractors billed charges for services that qualify as covered services.
   C. "Allowed Amount" means the amount designated in the Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular member, pursuant to this Contract or its Attachments.
   D. "Behavioral Health Intellectual/Developmental Disability Tailored Plan (BH I/DD Tailored Plan)" has the same meaning as BH I/DD Tailored Plan as defined in N.C. Gen. Stat. § 108D-1(4). For purposes of this Contract, Trillium Health Resources is the BH I/DD Tailored Plan.
   E. "Business Associate Agreement (BAA)" is a Contract between a HIPAA-covered entity and HIPAA Business Associate that allows disclosures of and protects personal health information (PHI) as required by HIPAA.
   F. "Catchment area" shall mean the geographic service area and a defined grouping of counties.
   G. "Clean Claim" means a claim that can be processed without obtaining additional information from the Contractor of the services or from a third party in order to adjudicate the claim. It does not include a claim under review for medical necessity, or a claim that is from a Provider that is under investigation by a governmental agency for fraud or abuse.
   H. "Continuous Quality Improvement (CQI)" refers to a continuous effort to achieve measurable improvements in the efficiency, effectiveness, and accountability of an organization. This process is designed to improve the quality of services by tracking performance through outcome and performance measures. (The following link provides a description of what the Centers for Medicare and Medicaid Services (CMS) expects with regard to Continuous Quality Improvement: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf)
   I. "Contract" refers to this Contract between the BH I/DD Tailored Plan and Contractor and shall mean as set forth in G.S. §58-50-270.
   J. "Contractor" means Contractor Name, the provider of services pursuant to this Contract, including all staff and employees of Contractor. Contractor shall, as a party to this Contract, be considered a Network Provider.

K. "Contract Year" means the period beginning when the BH I/DD Tailored Plan begins covering services under this Contract until the next June 30 and each subsequent twelve-month period thereafter.
L. "Controlling Authority" means as defined in this Contract.
M. "Cost-Sharing Amounts" means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Contract, when applicable.
N. "Department" means the North Carolina Department of Health and Human Services (DHHS) and includes the Division of Health Benefits (DHB) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).
O. "Emergency services" With respect to an emergency service, covered inpatient and outpatient services that:
    i. are furnished by a Contractor that is qualified to furnish such services; and
    ii. are needed to evaluate or stabilize an emergency medical condition.
P. "Health Care Provider" shall mean as set forth in G.S. §58-50-270.
Q. "Medical Record" means a single complete record, maintained by the Contractor of services, which documents all of the treatment plans developed for, and behavioral health services received by a Member.
R. "Member", unless otherwise specifically indicated in the Contract, refers to (1) a Medicaid beneficiary whose Medicaid eligibility arises from residency in a county covered by the BH I/DD Tailored Plan or who is currently enrolled in and receiving benefits through the BH I/DD Tailored Plan and (2) a Recipient who is actively receiving a State-funded Service or State-funded function, paid for by State Funds or Federal Block Grant Funds.
S. "Network Provider" shall mean as defined in 42 CFR 438.2.
T. "Notice" means a written communication between the parties delivered by trackable mail, electronic means, facsimile, or by hand.
U. "Party" refers only to the Contractor as defined in this Contract or the BH I/DD Tailored Plan; the two signatories to this contract.
V. "Post stabilization services" or "Post stabilization care services" shall mean as defined in 42 CFR §422.113 and §438.114.
W. "Prepaid Inpatient Health Plan (PIHP)" is an entity that (1) provides medical services to a Member under a contract with a State agency on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional service for its Members; and (3) does not have a comprehensive risk contract.
X. "Provider Operations Manual" or "Provider Manual" means the provider manual and any billing manuals adopted by the BH I/DD Tailored Plan and may include, without limitation, requirements relating to billing, credentialing, utilization management, quality management, grievances and appeals, on-site reviews and State requirements, and may be unilaterally amended from time to time by the BH I/DD Tailored Plan.
Y. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of BH I/DD Tailored Plan's contracts with DHHS and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in the attachments to this Contract.

Z. "Unmanaged Visits" refers to visits not requiring prior authorization.

2. BASIC RELATIONSHIP.

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

B. Department authority related to the Medicaid Program. The Contractor agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

3. ENTIRE CONTRACT/ MODIFICATIONS/ADMENDMENTS.

A. This Contract, consisting of the Procurement Contract for the Provision of Services and all Appendices and Attachments, constitutes the entire Contract between the BH I/DD Tailored Plan and the Contractor for the provision of services to Members. This contract shall supersede and replace any current Medicaid and/or State contract between the Contractor and BH I/DD Tailored Plan. Except for changes to Controlling Authority published by Centers for Medicare and Medicaid Services (CMS), the BH I/DD Tailored Plan, the Department, its divisions and/or its fiscal agent, any alterations, amendments, or modifications in the provision(s) of this Contract shall be in writing, signed by all parties, and attached hereto.

B. Assignment.

   i. The Contractor's duties and obligations under this contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.

   ii. The BH I/DD Tailored Plan shall notify the Contractor, in writing, of any duties or obligations that are to be delegated or transferred, prior to the delegation or transfer.

C. Amendments.

   i. Subject to negotiation. Either Party may propose an amendment to this Contract, the terms of which are subject to negotiation and mutual Contract of the Parties. Either Party may initiate an Amendment pursuant to this subsection by submitting an amendment proposal to the notice contact of other Party.

Such proposal shall contain, at a minimum, a summary of the proposed amendment and the reason for the proposed amendment. The receiving Party shall not be obligated to consider, engage with the initiating Party, or enter into a proposed Amendment subject to negotiation and the proposed Amendment shall not be effective unless executed by both Parties.

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

4. CONTROLLING AUTHORITY.

A. This Contract is required by State and Federal law; including 42 C.F.R. §438.206 and §438.214 and shall be governed by the following, including any subsequent revisions or amendments thereto, (hereinafter referred to as the "Controlling Authority"):

i. Title XIX of the Social Security Act and its implementing regulations, N.C.G.S. Chapter 108A, the North Carolina State Plan for Medical Assistance, the applicable North Carolina Medicaid waiver(s) authorized by CMS; and

ii. The federal anti-kickback statute, 42 U.S.C. §1320a-7b(b) and its implementing regulations; the federal False Claims Act, 31 U.S.C. §3729 – 3733 and its implementing regulations; and the North Carolina Medical Providers False Claims Act, N.C. Gen. Stat. §108A-70-10 *et seq*.; and

iii. All federal and state Member rights and confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards, 45 CFR Part 164, alcohol and drug abuse patient records laws codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2, the Health Information Technology for Economics and Clinical Health Act (HITECH Act) adopted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and those State laws and regulations denominated in Appendix F; and

iv. Regulations concerning access to care, utilization review, clinical studies, utilization management, care management, quality management, disclosure, enrollment and credentialing activities as set forth in 42 CFR parts 438, 441, 455, and 456; and

v. State licensure and certification laws, rules and regulations applicable to Contractor; and

vi. Applicable provisions of Chapter 122C of the North Carolina General Statutes; and

vii. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. §108A-54.2; and

viii. The North Carolina Medicaid and Health Choice Provider Requirements, N.C. Gen. Stat. Ch. 108C.
ix. The Americans With Disabilities Act, Titles VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Vocational Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and subsequent amendments and regulations developed pursuant thereto, to the effect that no person shall, on the grounds of sex, age, race, religious affiliation, handicap, national origin, sexual orientation, and transgender status be subjected to discrimination in the provision of any services or in employment practices; and
x. The Drug Free Workplace Act of 1988; and
xi. The requirements and reporting obligations related to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), Community Mental Health Services Block Grant (CMHSBG), Social Services Block Grant (SSBG) and accompanying state Maintenance of Effort (MOE) requirements; Projects to Assist in the Transition from Homelessness (PATH) formula grant; Strategic Prevention Framework – State Incentive Grant (SPF-SIG), Safe and Drug Free Schools and Communities Act (SDFSCA), and all other applicable federal grant program funding compliance requirements, if applicable.
xii. Regulatory Requirements and any other applicable federal or state laws, rules or regulations, in effect at the time the service is rendered and concerning the provision or billing of Medicaid reimbursable or State funded Mental Health, Intellectual and Developmental Disabilities and Substance Abuse (MH/IDD/SA) services; and
xiii. The BH I/DD Tailored Plan's Provider Operations Manual and the BH I/DD Tailored Plan contracts with the Department.

B. Compliance with state and federal laws. The Contractor understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement Contracts, or other court orders that apply to the Contract and the BH I/DD Tailored Plans Managed Care and State funded Services contract with NC DHHS, and all persons or entities receiving state and federal funds. The Contractor understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Contract, or any violation of the BH I/DD Tailored Plan's contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
C. Compliance with state laws. The Contractor understands and agrees that it is subject to all state laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the BH I/DD Tailored Plan's State-funded Services contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state funds. The Contractor understands and agrees that any violation by a provider of a state law relating to the delivery of services pursuant to this contract, or any violation of the BH I/DD Tailored Plans contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under Federal or state law.
D. Contractor agrees to operate and provide services in accordance with and pursuant to the Controlling Authority and the terms of this Contract. Contractor shall be responsible for keeping abreast of changes to Controlling Authority and will provide education and

training to its staff and employees as it pertains to changes from the Controlling Authority as appropriate. Contractor shall develop and implement a compliance program in accordance with 42 U.S.C. §1396a(kk)(5).

E. Contractor shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of the BH I/DD Tailored Plan, which may be set forth and/or summarized in the Provider Manual. Contractor's failure to comply with such policies could result in a denial, a reduction of payment to the Contractor, sanction as set forth in the Provider Manual, this Contract, and Regulatory Requirements, or termination of this Contract. The BH I/DD Tailored Plan shall make the Provider Manual available to the Contractor. In the event of a material change to the Provider Manual, the BH I/DD Tailored Plan will provide Contractor with at least thirty (30) days' advance written notice of such change. Such notice may be given through a periodic provider newsletter, or any other written method (electronic or paper). If there is any conflict between this Contract and the Provider Manual, this Contract will control.

F. Contractor agrees to carry out its respective obligations under this Contract in accordance with Controlling Authority, the Provider Manual and all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Contractor's noncompliance with applicable Regulatory Requirements or this Contract, paybacks, sanctions, penalties or liquidated damages are imposed on BH I/DD Tailored Plan, BH I/DD Tailored Plan may, in its sole discretion, offset such amounts against any amounts due to the Contractor from BH I/DD Tailored Plan or require Contractor to reimburse BH I/DD Tailored Plan for such amounts.

5. TERM.

A. This Contract is effective December 1, 2022 to June 30, 2023 and shall auto-renew annually on July 1 of each year thereafter. Either party may notify the other no less than sixty (60) days prior to July 1 of the current contract year if they do not wish to auto-renew for an additional term. This Contract shall not exceed the term of the BH I/DD Tailored Plan's contract with the Department. The BH I/DD Tailored Plan reserves the right to impose shorter time limits on the term of this Contract should Contractor fail to comply with the terms of this Contract. Contractor understands that State and Federal statutory and regulatory requirements as set forth in this Contract or Controlling Authority may be changed or updated during the term and sequential terms of this Contract.

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

6. CHOICE OF LAW/FORUM.

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

7. HEADINGS.

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

8. COUNTERPARTS.

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

9. NONWAIVER.

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

10. DISPUTE RESOLUTION AND APPEALS.

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

11. SEVERABILITY.

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

12. NOTICE.

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

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

13. ADMINISTRATIVE ACTIONS, SANCTIONS AND TERMINATION.

A. Either party may terminate this Contract if Federal, State or local funds allocated to the BH I/DD Tailored Plan are revoked or terminated in a manner beyond the control of the BH I/DD Tailored Plan for any part of the Contract period. If Federal, State, or local funds allocated to the BH I/DD Tailored Plan are reduced in a manner beyond the control of the BH I/DD Tailored Plan, the BH I/DD Tailored Plan will notify Contractor and provide payment to Contractor for services provided which were authorized by the BH I/DD Tailored Plan prior to the notification and for which Contractor has been qualified and credentialed.

B. Contractor understands, acknowledges and agrees that BH I/DD Tailored Plan may issue an educational (technical assistance) or warning letter, require a plan of correction, or impose administrative actions or sanctions against Contractor as the result of program integrity and any other monitoring activities. Possible administrative actions and sanctions are outlined in the Provider Manual and include but are not limited to increased monitoring/probation, limited or a suspension of referrals, moratorium on site or service expansion, payment suspension, site or service specific suspension or termination, full contract suspension, full contract termination and/or exclusion from participation in BH I/DD Tailored Plan's Provider Network. Contractor further understands, acknowledges and agrees that BH I/DD Tailored Plan is not required to issue an educational (technical assistance) or warning letter or plan of correction prior to the imposition of administrative actions or sanctions.

C. In accordance with BH I/DD Tailored Plan accrediting body requirements, BH I/DD Tailored Plan may also suspend this Contract in response to any serious health or safety risk to Members identified by the BH I/DD Tailored Plan Chief Medical Officer or other Senior Clinical Staff Person, and such suspension shall remain in effect during the pendency of any investigation into such health or safety risk.

D. This contract may be terminated without cause (i) at any time upon mutual consent of both parties or (ii) upon sixty (60) days notice of termination by one of the contracting parties.

E. The BH I/DD Tailored Plan is permitted to immediately suspend some or all activities under this Contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The BH I/DD Tailored Plan is permitted to immediately terminate a provider contract upon a confirmed finding of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State.

F. In the event this Contract is terminated for cause, cause may include, but is not limited to:

   i. Issuance by the Department of a revocation or suspension of Contractor's license to operate or issues a Type A1 penalty against Contractor; issuance of a payment suspension against Contractor in accordance with 42 CFR §455.23; or issuance of a revocation of state and/or federal funding against Contractor in accordance with 42 C.F.R. § 455.410 and/or 10A NCAC 26C .0504; or

   ii. Termination or suspension of contractor's participation in the Medicare program, NC Medicaid program, or another state's Medicaid program; or

   iii. Termination of Contractor for cause from participation in another BH I/DD Tailored Plan's provider network or the provider network of any other managed care organization; or

iv. Any other loss of, or sanction against, required facility or professional licensure, accreditation or certification of the Contractor; or
v. Determination by BH I/DD Tailored Plan that Contractor fails to meet credentialing, certification, accreditation or licensure standards prescribed by Controlling Authority;
vi. Determination by BH I/DD Tailored Plan that Contractor has failed to provide services as specified in the Contract, including a failure to comply with Controlling Authority; or
vii. Determination by BH I/DD Tailored Plan that the conduct of Contractor or the standard of services provided threatens to place the health or safety of any Member(s) in jeopardy.
viii. Determination by BH I/DD Tailored Plan that Contractor is engaged in fraudulent or abusive billing, documentation or clinical practices; or
ix. Determination by BH I/DD Tailored Plan that Contractor has provided fraudulent, misleading or misrepresented information to BH I/DD Tailored Plan or any Member(s);
x. Failure by Contractor to cooperate with any investigation, audit or post-payment review conducted by BH I/DD Tailored Plan or failure to provide timely, complete and accurate documentation of services as required by this Contract; or
xi. Failure by Contractor to timely reimburse the BH I/DD Tailored Plan for overpayment(s) identified by the BH I/DD Tailored Plan or failure to comply with any payment plan authorized by the BH I/DD Tailored Plan for the repayment of any overpayment(s);
xii. Contractor's failure to have an Electronic Health Record as set forth in G.S. 90-414.4; or
xiii. Any other material breach of this Contract not described above.

G. In the event BH I/DD Tailored Plan issues a sanction or terminates this Contract, Contractor may submit a request for reconsideration of administrative actions and sanctions as outlined in the Provider Manual.
H. In the event that Federal and State laws should be amended or judicially interpreted so as to render the fulfillment of the Contract on the part of either party unfeasible or impossible, both the Contractor and the BH I/DD Tailored Plan shall be discharged from further obligation under the terms of this Contract, except for settlement of the respective debts and claims up to the date of termination or as otherwise required by this Contract.
I. Change In Law. Except as set forth in the previous section, if there is a change in any law, regulation, rule, state or federal, which affects this Contract or the activities of either party under this Contract, or any change in the judicial or administrative interpretation of any such law, regulation or rule and BH I/DD Tailored Plan reasonably believes in good faith that the change will have a substantial adverse effect on BH I/DD Tailored Plan operations or its rights or obligations under this Contract, then PIHP may amend this Contract as set forth in Art. I., Sec. 3.C.ii.

14. EFFECT OF TERMINATION.

A. Upon notice of termination, a post-payment review of billing, documentation and other fiscal records may be performed and any adjustments for amounts due or owed to either party shall be added or deducted from the final Contract payments.

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

15. NON-EXCLUSIVE ARRANGEMENT.

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

16. NO THIRD PARTY CONTRACT RIGHTS CONFERRED.

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

ARTICLE II:
RIGHTS AND OBLIGATIONS OF THE CONTRACTOR

1. DISCLOSURE.

A. The Contractor shall make those disclosures to the BH I/DD Tailored Plan as are required to be made to DHHS pursuant to 42 C.F.R. §455.104 and 106 and are required by the BH I/DD Tailored Plan's accrediting body. The BH I/DD Tailored Plan will share accrediting body requirements with Contractor upon request.

B. To the extent, any of the above required disclosure information is captured in current or existing Medicare or NC Medicaid enrollment application documentation, the BH I/DD Tailored Plan shall accept electronic or paper copies of such documentation as meeting this requirement. Entities no longer enrolled in Medicaid or Medicare will be required to independently meet all disclosure requirements of this Paragraph, federal and state laws, rules and regulations, and the BH I/DD Tailored Plan's accrediting body.

C. Provider ownership disclosure. The Contractor agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs.

D. The Contractor agrees to notify, in writing, the BH I/DD Tailored Plan and the NC Department of Health and Human Services of any criminal conviction within twenty (20) days of the date of the conviction.

2. LICENSES, ACCREDITATIONS, CREDENTIALING AND QUALIFICATIONS.

A. The Contractor shall maintain all licenses, certifications, accreditations, credentialing and registrations required for its facilities and staff providing services under the Contract, as are required by the Controlling Authority. Should Contractor receive notice of a sanction by any applicable licensing board, certification or registration agency, or accrediting body or other authority which affects the ability of Contractor to bill the BH I/DD Tailored Plan for services, the Contractor shall forward a copy of the notice to the BH I/DD Tailored Plan as outlined in the Provider Manual.

B. The Contractor shall not bill the BH I/DD Tailored Plan:

   i. For any services provided by Contractor during any period of revocation or suspension of required credentialing, licensure or accreditation of the Contractor's facility;

   ii. For any services provided by Contractor's staff during any period of revocation or suspension of the staff's required certification, licensure, or credentialing.

C. The Contractor certifies that, at the time of execution of this Contract, neither Contractor nor any of its staff or employees are excluded from participation in Federal Health Care Programs under section 1128 of the Social Security Act, 42 C.F.R. § 455.410, and/or 42 CFR Part 1001. Should Contractor receive a notification of exclusion of Contractor or any of its staff or employees by the U.S. Office of Inspector General, CMS or any other

State Medicaid program, Contractor shall notify the BH I/DD Tailored Plan of the exclusion and its plan for compliance as outlined in the Provider Manual.

D. Contractor, upon written request by the BH I/DD Tailored Plan, shall provide proof of Contractor accreditation and copies of accreditation reports as part of the credentialing process.
E. The BH I/DD Tailored Plan will conduct an assessment of the Contractor's qualifications to remain in the BH I/DD Tailored Plan's network at a minimum of once every three (3) years, unless otherwise required by the Department.

3. EVENT REPORTING AND ABUSE/ NEGLECT/ EXPLOITATION.

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

4. BILLING AUDITS, DOCUMENTATION AND RECORDS RETENTION.

A. Unmanaged Visits do not require prior authorization. All service delivery, both managed and unmanaged, require documentation and record retention in accordance with this section.
B. The Contractor shall participate in and use best efforts to comply with the BH I/DD Tailored Plan's Utilization Management (UM) process, which may include requirements for pre-authorization, concurrent review and care management, credentialing review, and a retrospective utilization review of services provided for Members whose services are reimbursed by the BH I/DD Tailored Plan. The Contractor shall provide the BH I/DD Tailored Plan with all necessary clinical information for the BH I/DD Tailored Plan's UM process. For purposes of this Article II Section 4, Contractor shall provide specifically denominated clinical or encounter information required by the BH I/DD Tailored Plan to meet State and Federal monitoring requirements within fifteen (15) calendar days of the request, except that BH I/DD Tailored Plan may grant additional time to respond for good cause shown and depending upon the size and scope of the

request. Additionally, Contractor will provide any documentation directly to the B H I / D D Tailored Plan for review when requested. Contractor may satisfy any request for information by either paper or electronic/digital means.

C. The Contractor shall be responsible for completion of all necessary and customary documentation required for the services provided under this Contract in accordance with Controlling Authority.
D. Documentation must support the billing diagnosis, the number of units provided and billed, and the standards of the billing code. The Contractor will be responsible for the adoption, assessment, collection, and disposition of fees in accordance with G.S. 122C-146.
E. The Contractor shall maintain all documentation and records supporting Member's medical necessity for the services and shall provide it to the BH I/DD Tailored Plan for an investigation, audit or review upon request, within time frames established by the BH I/DD Tailored Plan, except that BH I/DD Tailored Plan may grant additional time to respond for good cause shown and depending upon the size and scope of the request.
F. The Contractor agrees and understands that the BH I/DD Tailored Plan may inspect financial records concerning claims paid on behalf of Members, records of staff who delivered or supervised the delivery of paid services to Member demonstrating compliance with Controlling Authority, Members' clinical records, and any other clinical or financial items related to the claims paid on behalf of Members deemed necessary to assure compliance with the Contract. Contractor is also subject to audits, investigations and post-payment reviews conducted by the United States Department of Health and Human Services, including the Department's Office of Inspector General, CMS and the Department, or their agents.
G. Equipment purchased with non-unit cost reimbursement funds, such as start up or special purpose funding, title to assets purchased under this Contract in whole or in part rests with the Contractor so long as that party continues to provide the services which were supported by the contract; if such services are discontinued, disposition of the assets shall occur as approved by the DHHS.
H. Contractor agrees to maintain necessary records and accounts related to the Contract, including personnel and financial records in accordance with Generally Accepted Accounting Procedures and Practices to assure a proper accounting of all funds, including budget revisions. Contractor shall maintain detailed records of administrative costs and all other expenses incurred pursuant to the Contract including the provision of services and all relevant information relating to individual Member as required by Controlling Authority. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are resolved.
I. At a minimum of once every two (2) years the Contractor will participate in an audit of paid claims conducted by the BH I/DD Tailored Plan. BH I/DD Tailored Plan shall conduct an entrance interview at the outset of any such audit. Any paid claims determined to be out of compliance with Controlling Authority will require a repayment to the BH I/DD Tailored Plan as required by Controlling Authority. Any underpayments to Contractor will require payment by the BH I/DD Tailored Plan to the Contractor. Audits shall be arranged with the Contractor in advance, except when the BH I/DD Tailored Plan has received a credible allegation of fraud, the health, safety or welfare of Members is at risk, or the BH I/DD Tailored Plan is participating in a joint investigation with the Department, its Divisions, contractor(s) or another federal or state agency. At the conclusion of any such audit, the BH I/DD Tailored Plan shall conduct an exit conference

with Contractor to discuss any tentative negative findings and provide Contractor written documentation of findings. Based upon results of the audit the Contractor may be subject to additional auditing and/or may be required to submit a plan of correction and /or may be required to remit funds back to the BH I/DD Tailored Plan as required by Controlling Authority. BH I/DD Tailored Plan may use statistical sampling and extrapolate audit results in accordance with Controlling Authority.

J. In accordance with Controlling Authority, specifically 42 CFR §420.300 through §420.304, for any contracts for services the cost or value of which is $10,000 or more over a 12-month period, including contract for both goods and services in which the service component is worth $10,000 or more over a 12-month period, the Comptroller General of the United States, USDHHS, and their duly authorized representative shall have access to Contractor's books, documents, and records until the expiration of four (4) years after the services are furnished under the contract.

K. The Contractor shall maintain a medical record and adhere to the federal record retention schedule for each Member served, either in original paper copy or an electronic/digital copy. Contractor shall maintain and share, as appropriate, medical records and other documentation in accordance with professional standards, NC DHHS *Records Management and Documentation Manual for Providers* (APSM 45-2), *Rules for MH/DD/SAS Facilities and Services* (APSM 30-1) and the *Basic Medicaid Billing Guide,* and any other applicable federal and state laws, rules and regulations, including but not limited to 42 CFR 438.208(b)(5). Contractor shall maintain confidentiality of member medical records and personal information and other health records as required by law. Medical records shall be maintained at the Contractor level; therefore, Members may have more than one record if they receive services from more than one Contractor. BH I/DD Tailored Plan shall monitor medical record documentation to ensure that the standards are met. BH I/DD Tailored Plan shall have the right to inspect Contractor records without prior notice. BH I/DD Tailored Plan shall also require Contractor to submit a plan for maintenance and storage of all records for approval by the BH I/DD Tailored Plan or transfer copies of medical records of Members served pursuant to this Contract to BH I/DD Tailored Plan in the event that the Contractor closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state or any other reason. The BH I/DD Tailored Plan has the sole discretion to approve or disapprove such plan. BH I/DD Tailored Plan shall not be held liable for any Contractor records not stored, maintained, or transferred pursuant to this provision so long as it has attempted, in good faith, to obtain a written plan for maintenance and storage or a copy of such records from the Contractor. If this Contract is terminated or if the Contractor closes network operations (but continues to have operations elsewhere in the State), the Contractor shall either: 1) provide copies of medical records of Members to the BH I/DD Tailored Plan, or 2) submit a plan for maintenance and storage of all records for approval by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan has the sole discretion to approve or disapprove such plan.

L. Contractor shall make available to the BH I/DD Tailored Plan its accounting records for the purpose of audit by State authorities and, when required by general statute, have an annual audit by an independent certified public accountant. A copy will be forwarded to the office of the State Auditor and the BH I/DD Tailored Plan.

M. Access to Contractor records. The Contractor agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Contract and any records, books, documents, and papers that relate to the Contract and/or the

Contractors performance of its responsibilities under this Contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

i. The United States Department of Health and Human Services or its designee;
ii. The Comptroller General of the United States or its designee;
iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee;
iv. The Office of Inspector General;
v. North Carolina Department of Justice Medicaid Investigations Division;
vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
vii. The North Carolina Office of State Auditor, or its designee;
viii. A state or federal law enforcement agency; and
ix. Any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

N. The Contractor shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by BH I/DD Tailored Plan, NCDHHS or CMS. BH I/DD Tailored Plan shall not be required to coordinate in advance with Contractor regarding BH I/DD Tailored Plans financial, clinical or program integrity auditing/monitoring activities.

O. Nothing in this Article II Section 4 shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation

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

A. Contractor agrees to provide, at no cost to BH I/DD Tailored Plan, prompt, reasonable and adequate access to BH I/DD Tailored Plan, any records, books, documents, and papers that relate to the Contract and/or Contractor's performance of its responsibilities under this Contract, for purposes of examination, audit, investigation, contract administration or any other purpose BH I/DD Tailored Plan deems reasonably necessary to perform its regulatory and oversight activities of the Contractor. BH I/DD Tailored Plan shall not be required to coordinate in advance with Contractor regarding Trillium's financial, clinical or program integrity auditing/monitoring activities.

B. Contractor understands that whenever BH I/DD Tailored Plan receives a credible allegation of fraud, abuse, overutilization or questionable billing practice(s), the BH I/DD Tailored Plan is required to investigate the matter and where the allegation(s) prove Tailored Plans credible, the BH I/DD Tailored Plan is required to provide DHB with the Contractor name, type of provider, source of the complaint, and approximate dollars involved. Contractor agrees to cooperate in any such investigation, and failure to do so, may result in possible sanction up to and including termination of this Contract. Contractor understands that the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office or DHB, at their discretion, may conduct preliminary or full investigations to evaluate the suspected fraud, abuse, over utilization or questionable billing practices and the need for further action, if any. Fraudulent billing may include,

but is not limited to, unbundling services, billing for services by non-credentialed or non-licensed staff, or billing for a service that Contractor never rendered or for which documentation is absent or inadequate.

C. If the BH I/DD Tailored Plan determines Contractor failed to comply with Controlling Authority and has been reimbursed for a claim or a portion of a claim that the BH I/DD Tailored Plan determines should be disallowed, or that Contractor has been paid for a claim that was fraudulently billed to the BH I/DD Tailored Plan, the BH I/DD Tailored Plan will provide notice to the Contractor of the intent to recoup funds. Such notice of adverse action shall identify the Members name and dates of service in question, the specific determination made by the BH I/DD Tailored Plan as to each claim, and the requested amount of repayment due to the BH I/DD Tailored Plan. Contractor shall have thirty (30) days from date of such notification to either appeal the determination of the BH I/DD Tailored Plan or to remit the invoiced amount.

D. If the BH I/DD Tailored Plan or Contractor determines that the Contractor has received payment from the BH I/DD Tailored Plan as a result of an error or omission, the BH I/DD Tailored Plan will provide notice to the Contractor of its intent to recoup funds related to errors or omissions. The BH I/DD Tailored Plan will provide an invoice to the Contractor including the Members name and dates of service in question. Contractor shall have thirty (30) days from date of such notification to either appeal the determination of the BH I/DD Tailored Plan or to remit the invoiced amount.

E. When authorized by Controlling Authority, Contractor may request a reconsideration of a recoupment or overpayment identified pursuant to this Article II Section 5, as outlined in the BH I/DD Tailored Plan Provider Manual.

F. Contractor understands and agrees that self-audits are encouraged by the BH I/DD Tailored Plan.

G. Contractor shall be required to comply with BH I/DD Tailored Plan Utilization Management Programs, Quality Management Programs, and Provider Sanction Programs, except to the extent that any of these programs conflict with Contractors professional or ethical responsibility or interfere with Contractors ability to provide information or assistance to patients.

6. FEDERALLY REQUIRED CERTIFICATIONS AND ATTACHMENTS.

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

a. Appendix A. Federal Assurances Certification Regarding Environmental Tobacco Smoke;
b. Appendix B. Federal Assurances Certifications Regarding Lobbying;
c. Appendix C. Federal Assurances Certification Regarding Drug-Free Workplace Requirements;
d. Appendix D. Federal Assurance Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions;
e. Appendix E. Outcomes and Reporting Measures;
f. Appendix F. Agency/Practitioner or Group/Hospital/ICF Addendum;
g. Appendix G. North Carolina Department of Health and Human Services Business Associate Agreement;
h. Attachment A. Contracted Services and Qualified/Approved Sites;
i. Attachment B. Deficit Reduction Act;

j. Attachment C. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members;
k. Attachment D. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members;
l. Attachment E. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
m. Attachment F. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members
n. Attachment G. Indian Health Care Providers

7. COMPLAINTS AND GRIEVANCES.

A. The Contractor shall address all clinical concerns of the Members as related to the clinical services provided to the Members pursuant to this Contract. Contractor shall refer any unresolved Member concerns or requests to the BH I/DD Tailored Plan. In accordance with 10A NCAC 27G .0201(a)(18), the Contractor shall have in place a written policy for a Complaint and Grievance Process and procedures for review and disposition of Member complaints and grievances. The process shall be accessible to all Members and conducted in a fair and impartial fashion.

B. The BH I/DD Tailored Plan may receive complaints directly from internal staff, Members, contracted providers, service providers, the Department or other third parties, which concern or pertain to the Contractor. If the BH I/DD Tailored Plan receives a complaint or grievance concerning the Contractor, the BH I/DD Tailored Plan shall process and resolve the complaint or grievance in accordance with Controlling Authority, including applicable State or Federal rules and regulations. In the event a complaint or grievance results in an investigation, review, or audit of Contractor by BH I/DD Tailored Plan, Contractor shall fully cooperate with all investigative requests of the BH I/DD Tailored Plan. Contractor's failure to cooperate with the BH I/DD Tailored Plan's investigation, review, or audit performed pursuant to this Article II Section 7, shall constitute a material breach of this Contract.

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

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

A. Contractor shall use its best efforts to timely notify BH I/DD Tailored Plan any time a Member is admitted into its facility, continuously provide authorized and appropriate services to each Member, and routinely update BH I/DD Tailored Plan regarding each Member receiving services from Contractor. Contractor shall coordinate the discharge of Members with the BH I/DD Tailored Plan to ensure that appropriate services are arranged following discharge and to link Members with other providers or community assistance. Contractor shall also allow appropriately credentialed BH I/DD Tailored Plan staff direct access to any Members, if requested by Member, determined to be clinically appropriate by the Member's treating physician, and/or requested in advance by the BH

I/DD Tailored Plan. Contractor shall notify BH I/DD Tailored Plan representative in writing of all Member discharges at least thirty (30) days in advance of the anticipated date of discharge, if commercially reasonable, and in no event less than fourteen (14) days in advance of the anticipated date of discharge, unless exceptional circumstances necessitate a shorter notice.

B. Contractor shall notify the BH I/DD Tailored Plan when a Member in a high acuity clinical setting is being discharged.
C. The BH I/DD Tailored Plan understands the importance of Member-Contractor matching and that problems or incompatibilities arise in the therapeutic relationship. Nevertheless, Contractor shall with the consent of the Member, collaborate with Member, Member's family members, and the BH I/DD Tailored Plan to assure continuity of care and that there is no disruption of service. The BH I/DD Tailored Plan will work collaboratively with the Contractor to resolve any problems of continuity of care or in transferring the Member to another provider.
D. When Contractor is accepting referrals, Contractor shall provide services to Members
    i. within two (2) hours of an emergency or immediately for a life threatening emergency;
    ii. within forty-eight (48) hours when the service need is urgent; and
    iii. within ten (10) days when service need is routine.
E. Contractor shall meet the following access standards related to office wait times:
    i. For scheduled appointments, Members shall be seen within sixty (60) minutes after the appointed meeting time;
    ii. For walk-in appointments, Members shall be seen within two (2) hours after their arrival and, if that is not possible, Contractor must schedule an appointment for the next available day; and
    iii. For emergencies, Members shall receive face-to-face emergency care within two (2) hours after the request for care is initiated, except that life-threatening emergencies shall be managed immediately.
F. Non-Discrimination Equitable Treatment of Members. The Contractor agrees to render provider services to Members with the same degree of care and skills as customarily provided to the Contractors patients who are not members, according to generally accepted standards of medical practice. The Contractor agrees that members and non-members should be treated equitably. The Contractor agrees not to discriminate against members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
G. Residential Substance Use Disorder Treatment Providers. If Contractor is contracted to provide residential substance use disorder treatment, Contractor is required to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
H. Commitment Orders. If Contractor provides services to Members pursuant to Commitment Orders, Contractor shall notify BH I/DD Tailored Plan of the Commitment Order upon receipt, in a manner designated by the BH I/DD Tailored Plan.
I. Perinatal Care. If Contractor is a provider of perinatal care, Contractor shall ensure all pregnant women enrolled in managed care through the BH I/DD Tailored Plan receive a coordinated set of high-quality clinical maternity services consistent with the BH I/DD Tailored Plan's Pregnancy Management Program. A key feature of the program is the continued use of a standardized screening tool to identify and refer women at risk for an adverse birth outcome to the Care Management High Risk Pregnancy (CMHRP) program, a more intense set of care management services that will be coordinated and

provided by Local Health Departments. If Contractor is an Obstetrician, Contractor shall comply with the Department's Pregnancy Management Program.

J. Interpreting and Translation Services.
    i. Contractor must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
    ii. Contractor must ensure staff are trained to appropriately communicate with patients with various types of hearing loss.
    iii. Contractor shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

9. PROPRIETARY INFORMATION AND INTELLECTUAL PROPERTY.

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

10. CONFIDENTIALITY.

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

11. CONTRACTOR ACCESSIBILITY.

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

a. Offer hours of operation that are no less than the hours of operation offered to Members or comparable to NC Medicaid Direct, if the Contractor serves only Medicaid beneficiaries;
b. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and

c. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Contractor will accept all referrals meeting criteria for services negotiated, approved by BH I/DD Tailored Plan, and offered by Contractor when there is available capacity.

12. ADVOCACY FOR MEMBERS.

During the effective period of this Contract, the Contractor shall not be restricted from communicating freely with, providing information to, or advocating for, Members regarding the Members' mental health, intellectual and developmental disabilities, or substance abuse care needs, medical needs, and treatment options regardless of benefit coverage limitations.

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

A. CMHSBG funds shall not be used to provide inpatient services;
B. SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except that SAPTBG funds may be used with the exception as described in 45 CFR 96.135 (c), along with documentation of the receipt of prior written approval of the DMH/DD/SAS Director of Financial Operations and the Chief of Addictions and Management Operations;
C. SAPTBG and Mental Health Block Grant (MHBG) funds are prohibited to be used to make, or to allow to be made, any cash payments to any Members or intended Members of health or behavioral health services. The provision of cash or cash cards is strictly prohibited, as is the provision of gift cards, which are considered to be cash equivalents.
D. SAPTBG and MHBG funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment;
E. SAPTBG and MHBG funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement);
F. SAPTBG and MHBG funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity;
G. SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;
H. SAPTBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, holding facilities, etc.);
I. SAPTBG and MHBG funds are prohibited to be used towards the annual salary of any contractor or subcontractor, including BH I/DD Tailored Plan, provider, or Contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule;
J. Contractors receiving federal funds are required to receive prior written approval from the Chief of the Addictions and Management Operations Section regarding the use of evidence-based program incentives, including the specification of the type(s) and

equivalent dollar value(s) of any such nominal incentives offered, and the manner of utilization of any such approved incentives for clients, recipients, students, or other persons. "Nominal incentives" are restricted to those of no more than twenty-five dollars ($25.00) in value per Member , per event. Programs are strictly prohibited from utilizing any incentive items that could potentially be converted to cash, or that could be used for the purchase of any age-restricted product, such as tobacco, alcohol, drugs, weapons, or lottery tickets or any sexually oriented materials;

K. Federal funds shall not be utilized for law enforcement activities;

L. No part of any federal funding shall be used for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any state legislative body itself;

M. No part of any federal funding shall be used to pay the salary or expenses of any grant or contract Member, or agent acting for such Member, related to any activity designed to influence legislation or appropriations pending before the Congress or any state legislature;

N. PATH (as applicable) formula grant funds shall not be expended:

   i. to support emergency shelters or construction of housing facilities;

   ii. for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or

   iii. to make cash payments to intended Members of mental health or substance abuse services, except as permitted by 45 CFR § 96.135(c).

14. TRAINING AND TECHNICAL ASSISTANCE.

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

15. PRESERVATION OF DHHS PUBLIC FUNDS.

Contractor acknowledges funds used for provider payments are government funds. Contractor providing MH/IDD/SA services paid for with State and/or federal block grant funds shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies. Providers offering mental health and/or substance abuse services on an outpatient basis shall demonstrate good faith efforts to seek and/or maintain membership on major commercial insurance panels, including but not limited to BlueCross BlueShield.

16. RESPONSE TO SURVIVORS OF DISASTERS AND OTHER HAZARDS.

If designated by the BH I/DD Tailored Plan, Contractor providing MH/IDD/SA services paid for with State and/or federal block grant funds, under the direction of the BH I/DD Tailored Plan and in coordination with the local Emergency Management agencies shall deploy

behavioral health disaster responders to deliver behavioral health disaster services to survivors and other responders within the counties served by the BH I/DD Tailored Plan. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/teletypewriter (TTY) machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g. The Federal Emergency Management Agency (FEMA) Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined that survivors or other disaster responders are in need of longer term mental health, developmental disabilities and/or substance abuse services Contractor's behavioral health disaster responders shall refer such persons in need to the BH I/DD Tailored Plan or its designee for further assistance.

17. CLINICAL OUTCOME MEASURES.

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

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

18. INSURANCE.

A. The Contractor shall purchase and maintain Professional Liability Insurance as listed below from a company, or a self-insurance program that is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Self-insurance policies shall not be eliminated or reduced in coverage or limits below the stated minimums without thirty (30) days prior notice to the BH I/DD Tailored Plan.
    i. Professional Liability. The Contractor shall purchase and maintain professional liability insurance protecting the Contractor and any employee performing work under the Contract for an amount of not less than $1,000,000.00 per occurrence and proof of coverage at or exceeding $3,000,000.00 in the annual aggregate.
B. Contractor shall, purchase and maintain additional insurance coverage as specified in Appendix F. BH I/DD Tailored Plan reserves the right to review its insurance limits annually and revise them as needed. Contractor shall obtain coverage that may only be suspended, voided, canceled or reduced by the carrier upon thirty (30) days prior written notice to Contractor, which written notice shall be forwarded by Contractor to BH I/DD Tailored Plan within five (5) business days. Upon request, Contractor shall submit certificates of coverage to BH I/DD Tailored Plan. Upon DHB's request, BH I/DD

Tailored Plan shall submit copies of these certificates to DHB. Contractor acknowledges that:

i. Any loss of insurance shall justify the termination of this Contract in the BH I/DD Tailored Plan's sole discretion;
ii. Upon Contractor's notification of knowledge or notice of a claim, suit, criminal or administrative proceeding against Contractor and/or Practitioner relating to the quality of services provided under this Contract, BH I/DD Tailored Plan in its sole discretion shall determine within ten (10) days of receipt of notification whether termination of the Contract or other sanction is required; and
iii. All insurance requirements of this Contract shall be fully met unless specifically waived in writing by both the BH I/DD Tailored Plan and Contractor.

19. CONTRACTOR PERFORMANCE AND DATA SUBMISSION.

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

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

1. REIMBURSEMENT.

A. BH I/DD Tailored Plan will make available a copy of its policies and procedures to Contractor in compliance with G.S. §58-50-285. During the term of this Contract, BH I/DD Tailored Plan shall make available copies of its policies and procedures and prior to the execution of an amended contract with Contractor. BH I/DD Tailored Plan's policies and procedures shall not conflict with or override any term of this Contract including fee schedules referenced herein. In the event of a conflict between a policy or procedure and this Contract, the language in the Contract shall prevail.
B. BH I/DD Tailored Plan will provide a mechanism that allows Contractor to verify member eligibility before rendering services and reporting of eligibility information to the BH I/DD Tailored Plan.
C. The BH I/DD Tailored Plan shall reimburse Contractor for services provided to Members in accordance with the terms and conditions of this Contract, when such services have

been authorized by the BH I/DD Tailored Plan, except in those instance where treatment authorization is not required.

D. BH I/DD Tailored Plan shall have a reimbursement policy consistent with the requirements under G.S. 58-3-227(a)(5). BH/IDD Tailored Plan will apply claim edits based on guidelines from sources that may include, but not limited to CMS, American Medical Association (AMA), and State-specific policy and procedures, as set forth in the Provider Manual. In making payment determinations, Trillium shall utilize nationally recognized coding structures including the National Uniform Billing Code (NUBC), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD). Failure to follow appropriate coding guidelines may result in claim denial.

E. The BH I/DD Tailored Plan shall advise the Contractor of any change in funding patterns that would affect reimbursement to the Contractor based on availability of the various types of funds. Any changes to reimbursement shall be in writing to Contractor thirty (30) days prior to such change based on the availability of the various types of funds.

2. CONFIDENTIALITY OF CERTAIN CONTRACTOR INFORMATION.

A. If the Contractor discloses confidential information, as that term is defined in G.S. § 132-1.2, to the BH I/DD Tailored Plan in connection with the Contractor's performance of this Contract, the BH I/DD Tailored Plan can protect the information from public disclosure to the extent permitted by G.S. § 132-1.2, if the Contractor takes one or more of the following steps before disclosing the confidential information to the BH I/DD Tailored Plan. If the Contractor determines that all of the information on any given document constitutes trade secret information, as that term is defined in G.S. § 66-152(3), the Contractor may designate the entire page as confidential by marking the top and bottom of the page with the word "CONFIDENTIAL" in upper-case bold-face type. If the Contractor determines that any given page of a document contains a mixture of trade secrets and non-confidential information, the Contractor may highlight the trade secrets and indicate in the margins that the highlighted text constitutes a confidential trade secret. By so marking any page, the Contractor warrants that it has formed a good faith opinion, upon advice of counsel or other knowledgeable advisors, that the items marked confidential meet the requirements of G.S. §§ 66-152(3) and 132-1.2(1). Pursuant to 1 NCAC 5B .1501 and 9 NCAC 6B .1001, price information may not be designated as confidential.

B. The BH I/DD Tailored Plan may serve as the custodian of the Contractor's trade secrets but not as an arbiter of claims against the Contractor's assertion of confidentiality. If an action is brought pursuant to G.S. § 132-9 to compel the BH I/DD Tailored Plan to disclose information marked confidential, the Contractor agrees that it will intervene in the action through counsel and participate in defending the BH I/DD Tailored Plan, and NC DHHS and its officials and employees against the action. The Contractor agrees that it shall hold the State and its employees, officials, and agents and the BH I/DD Tailored Plan and its officials and employees harmless from any and all damages, costs, and attorney fees awarded against the BH I/DD Tailored Plan or the State in the action. The BH I/DD Tailored Plan agrees to give the Contractor prompt written notice of any action seeking to compel the disclosure of Contractor's trade secrets. The BH I/DD Tailored Plan and the State shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The BH I/DD Tailored Plan and the State shall have no liability to Contractor with respect to the disclosure of Contractor's trade secrets

pursuant to an order issued by a court of competent jurisdiction pursuant to G.S. §132-9 or any other applicable law.

C. Liability. The Contractor understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the BH I/DD Tailored Plan, its employees, agents or subcontractors. Further, the Contractor understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the Contractor by the BH I/DD Tailored Plan or any judgment rendered against the BH I/DD Tailored Plan.

3. REFERRALS TO CONTRACTOR.

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

4. UTILIZATION MONITORING.

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

5. QUALITY ASSURANCE AND QUALITY IMPROVEMENT.

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

a. Provide Contractor with a copy of the current program and any subsequent changes within thirty (30) days of changes to the Quality Assessment and Performance Improvement Plan (QAPI) ;
b. Measure the performance of Contractor and Member specific outcomes from service provisions based on the quality indicators. Examples include, but are not limited to, conducting peer review activities such as identification of practices that do not meet standards, recommendation of appropriate action to correct deficiencies, and monitoring of corrective action by providers;
c. Measure outcomes in the areas of quality of life, functional status, and member satisfaction in collaboration with the Department and may involve the use of surveys administered by providers or involve development and piloting of novel survey instruments;
d. Ensure administration of surveys by providers as required and requested by the Department;
e. Ensure administration of the NC-TOPPS interview tool to members in a form and manner specified by the Department;
f. Provide support to providers tailored to advance State interventions and ensure provider's ability to achieve the goals outlined in the Quality Strategy;
g. Measure Contractor performance through medical record audits and clinical outcomes agreed upon by both Parties;

h. Monitor the quality and appropriateness of care furnished to Members and assure compliance with the rules established by the Mental Health Commission, the Secretary of DHHS and G.S. 122C-142;
i. Provide performance feedback to Contractor including clinical standards and the BH I/DD Tailored Plan expectations;
j. Follow up with Contractor concerning grievances reported to BH I/DD Tailored Plan by Members; and
k. Provide data about individual Members for research and study to the Contractor based on the parameters set by the BH I/DD Tailored Plan.
l. Data to Contractor. BH I/DD Tailored Plan will provide:
    i. Performance feedback reports or information if compensation is related to efficiency criteria.
    ii. Information on benefit exclusions; administrative and UM requirements (in contract); credential verification programs; quality assessment programs; and provider sanction policies.
    iii. Notification of changes in these requirements shall be provided by the BH I/DD Tailored Plan, allowing Contractor time to comply with such changes.

6. CARE MANAGEMENT/ COORDINATION OF CARE.

A. The BH I/DD Tailored Plan shall ensure the coordination of care with each Member's primary care provider and any behavioral health provider enrolled to provide care for each Member. The BH I/DD Tailored Plan shall coordinate the discharge of Members with Contractor to ensure that appropriate services have been arranged following discharge and to link Members with other providers or community assistance.
B. The BH I/DD Tailored Plan shall provide coordination of care to high risk Members discharged from twenty-four hour care as set forth in BH I/DD Tailored Plan's contracts with the Department.
C. If a Member requires medically necessary MH/IDD/SA services, the BH I/DD Tailored Plan shall arrange for Medicaid reimbursable services for the Member when possible.

7. AUTHORIZATION OF SERVICES.

A. The BH I/DD Tailored Plan shall determine medical necessity for those services requiring prior authorization as set forth in Controlling Authority, including DHB Clinical Coverage Policies.
B. Unless otherwise required by Controlling Authority, for those services requiring prior authorization, the BH I/DD Tailored Plan shall issue a decision to approve or deny a service within fourteen (14) calendar days after receipt of the request, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:
    i. The Member requests the extension; or
    ii. The Contractor requests the extension; or
    iii. The BH I/DD Tailored Plan justifies to the Department upon request:
        a) A need for additional information; and
        b) How the extension is in the Member's interest.
C. In those cases for services requiring prior authorization in which Contractor indicates, or BH I/DD Tailored Plan determines, that adherence to the standard timeframe could seriously jeopardize a Member's life or health or ability to attain, maintain, or regain maximum function, including but not limited to psychiatric inpatient hospitalization services, the BH I/DD Tailored Plan shall issue a decision to approve or deny a service

within three (3) calendar days after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:

i. The Member requests the extension; or
ii. The BH I/DD Tailored Plan justifies to the Department upon request:
    a) A need for additional information; and
    b) How the extension is in the Member's interest.

D. For those services requiring prior authorization, the BH I/DD Tailored Plan shall permit retroactive authorization of such services in instances where the Member has been retroactively enrolled in the Medicaid program or in the BH I/DD Tailored Plan program, or where the Member has primary insurance which has not yet paid or denied its claim. Retroactive authorizations include requests for deceased Members. The request for authorization must be submitted within ninety (90) days of primary denial or notice of enrollment.
E. Upon the denial of a requested authorization, the BH I/DD Tailored Plan shall inform Member's attending physician or ordering provider of the availability of a peer to peer conversation, to be conducted within one (1) business day.
F. For appeal information, please refer to the BH I/DD Tailored Plan Provider Manual.
G. In conducting prior authorization, BH I/DD Tailored Plan shall not require Contractor to resubmit any data or documents previously provided to BH I/DD Tailored Plan for the Member's presently authorized services.
H. CHAPTER 58 REQUIREMENTS. Pursuant to G.S. § 58-3-200(c), BH I/DD Tailored Plan shall not retract a determination that services, supplies or other items are covered under the BH I/DD Tailored Plan Benefit Plan after the services, supplies, or other items have been provided, nor shall BH I/DD Tailored Plan reduce payments for services, supplies or other items furnished in reliance on such a determination, except however that the BH I/DD Tailored Plan may retract such determination if its determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or the provider of the service, supply or other item.

ARTICLE IV:
BILLING AND REIMBURSEMENT

1. CONTRACTOR PAYMENT.

A. Payment under the Compensation Schedule. All payments under the Compensation Schedule are subject to the terms and conditions set forth in this Contract, the Provider Manual and any applicable billing manual and claim processing policies.
    i. By executing this Contract, Contractor certifies that BH I/DD Tailored Plan has made its schedule of fees available in compliance with G.S. §58-3-227(h).
B. Compensation under this Contract. Compensation shall be the "Allowed Amount" except as otherwise provided in this Contract. The Allowed Amount for covered services is the rate floor as defined by the North Carolina Division of Health Benefits ("NCDHB") and North Carolina Department of Health and Human Services which is one hundred percent (100%) of the amount payable based on the BH I/DD Tailored Plan's respective Medicaid Fee-for-Service Fee Schedule and State-funded Fee Schedule on the date of service (the "Rate Floor"); unless, the Allowable Charge is less than the Rate Floor in which case both Parties mutually agree as an alternative reimbursement arrangement that the Allowed Amount will be equal to the Allowable Charge.

C. Place of Service Pricing Rules. BH I/DD Tailored Plan fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

D. Fee Change Updates. Updated fee schedules shall become effective on the effective date of such fee schedule updates, as determined by the Payer ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, (i.e. the date on which such fee change is first used for reimbursement "Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payer is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

E. Code Change Updates. Payer utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

F. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Member is responsible to pay under the Coverage Contract will be subtracted from the Allowed Amount in determining the amount to be paid.

G. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on Member during a single occasion of surgery, reimbursement will be as follows:

    i. The procedure for which the Allowed Amount under the Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount;

    ii. the procedures with second greatest Allowed Amounts under the Compensation Schedule will be reimbursed at fifty percent (50%) of such Allowed Amounts; and

    iii. Any additional procedures will not be eligible for reimbursement.

H. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Contract, any payment arrangement entered into between Contractor and a third-party vendor of such services shall supersede compensation hereunder.

I. It is the Contractor's responsibility to verify the Member's Medicaid coverage prior to submitting claims to the BH I/DD Tailored Plan. If an individual presents for services who is not eligible for Medicaid and the Contractor reasonably believes that the

individual meets Medicaid financial eligibility requirements, Contractor shall offer to assist the individual in applying for Medicaid.

J. Member Billing. Contractor must notify any Member ahead of time and shall not bill the member for covered services, except for agreed upon specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit Contractor and Member from agreeing to continue non-covered services at the member's own expense, as long as the Contractor has notified the Member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the Member to receive the service.

K. Hold Member Harmless. The Contractor agrees to hold the Member harmless for charges for any covered service. The Contractor agrees not to bill a Member for medically necessary services covered by the BH I/DD Tailored Plan so long as the Member is eligible for coverage.

L. The BH I/DD Tailored Plan may unilaterally revise reimbursement rates under this Contract. Any changes to reimbursement shall be in writing to Contractor thirty (30) days prior to such change.

M. Contractor shall comply with all terms of this Contract even though a third party agent may be involved in billing the claims to the BH I/DD Tailored Plan. It is a material breach of the Contract to assign the right to payment under this Contract to a third party in violation of Controlling Authority, specifically 42 C.F.R. §447.10.

N. Contractor acknowledges that the BH I/DD Tailored Plan and this Contract covers only those Medicaid reimbursable, and state and/or federal block grant funded, MH/IDD/SA services as referenced in Attachment A, and does not cover other services outlined in the North Carolina State Plan for Medical Assistance. The Contractor may bill any such other services for Medicaid recipients directly to the North Carolina Medicaid program.

O. Contractor further understands that, regarding Medicaid services, there are circumstances that may cause a Member to be disenrolled from or by the BH I/DD Tailored Plan. If the disenrollment arises from Member's loss of Medicaid eligibility, the BH I/DD Tailored Plan shall be responsible for claims for the Member up to and including the Member's last day of eligibility. If the disenrollment arises from a change in the Member's Medicaid County of residence, BH I/DD Tailored Plan shall be responsible for claims for the Member up to the effective date of the change in Medicaid County of residence. In any instance of Member's disenrollment, preexisting authorizations will remain valid for any services actually rendered prior to the date of disenrollment.

P. Contractor shall bill BH I/DD Tailored Plan for all MH/IDD/SA services as described in Attachment A.

Q. For any provider subject to a rate floor, the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision. The BH I/DD Tailored Plan shall not consider any provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

2. SUBMISSION OF CLAIMS.

A. The BH I/DD Tailored Plan shall adjudicate claims as outlined in the BH I/DD Tailored Plan Provider Manual.

B. Billing Diagnosis submitted on claims must be consistent with the service provided.

C. If a specific service (as denominated by specific identifying codes such as CPT or HCPCS) is rendered multiple times in a single day to the same Member, the specific

service may be billed as the aggregate of the units delivered rather than as separate line items.

D. Claims must be submitted electronically either through HIPAA Compliant Transaction Sets; 837P – Professional claims, 837I – Institutional claims, or the BH I/DD Tailored Plan's secure web based billing system.

E. Contractor's claims shall be compliant with the National Correct Coding Initiative effective at the date of service.

F. Parties shall be compliant with the requirements of the National Uniform Billing Committee.

G. G.S. 58-3-225. Prompt claim payments under health benefits. The Contractor shall submit all claims to the BH I/DD Tailored Plan for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the Contractor's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the Contractor to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

   i. For Medical claims (including BH):
      a) The BH I/DD Tailored Plan shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the Contractor whether the claim is clean or pend the claim and request from the Contractor all additional information needed to process the claim.
      b) The BH I/DD Tailored Plan shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
      c) A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

   ii. For Pharmacy Claims:
      a) The BH I/DD Tailored Plan shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more
      b) A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.

   iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the BH I/DD Tailored Plan shall deny the claim per § 58-3-225 (d).
      a) The BH I/DD Tailored Plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

   iv. If the BH I/DD Tailored Plan fails to pay a clean claim in full pursuant to this provision, the BH I/DD Tailored Plan shall pay the Contractor interest and liquidated damages. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

   v. Failure to pay a clean claim within thirty (30) days of receipt will result in the BH I/DD Tailored Plan paying the Contractor liquidated damages equal to one percent (1%) of the total amount of the claim per day beginning on the

date following the day on which the claim should have been paid or was underpaid.

vi. The BH I/DD Tailored Plan shall pay the interest and liquidated damages from subsections (iv) and (v) as provided in that subsection and shall not require the Contractor to requests the interest or the liquidated damages.

H. BH I/DD Tailored Plan receives the claim, as indicated on the electronic data records.

I. The BH I/DD Tailored Plan shall not reimburse Contractor for "preventable conditions" as set forth in 42 C.F.R. § 438.3(g) The BH I/DD Tailored Plan shall not reimburse Contractor for "Provider Preventable Conditions."

J. The Contractor shall not submit claim or encounter data for services covered by Medicaid Managed Care and BH I/DD Tailored Plans directly to the Department.

3. PAYMENT OF CLAIMS.

A. The BH I/DD Tailored Plan shall reimburse Contractor for approved Clean Claims for covered services requiring prior authorization within thirty (30) days of the date of receipt. Clean claims for emergency services which do not require prior authorization shall be reimbursed within thirty (30) days of the date of receipt.

i. If the BH I/DD Tailored Plan denies payment of a claim the BH I/DD Tailored Plan shall provide Contractor the ability to electronically access the specific denial reason.

ii. "Claims Status" of a claim shall be available within five to seven (5-7) days of the BH I/DD Tailored Plan receiving the claim.

iii. If the BH I/DD Tailored Plan determines that additional information in either original or certified copy form is required for making the approval or denial of the claim, BH I/DD Tailored Plan shall notify the Contractor within eighteen (18) days after the BH I/DD Tailored Plan received the claim. The Contractor shall have ninety (90) days to provide the additional information requested, or the claim shall be denied. Upon BH I/DD Tailored Plan's receipt of the additional information from the Contractor, the BH I/DD Tailored Plan shall have an additional thirty (30) days to process the claim.

iv. The BH I/DD Tailored Plan is not limited to approving a claim in full or requesting additional information for the entire claim. Rather, as appropriate, part, and/or request additional information for only a part of the claim, as long as the BH I/DD Tailored Plan either approves, denies, or requests additional information for each part of the claim within the required eighteen (18) day period.

B. The BH I/DD Tailored Plan will not reimburse Contractor for services provided by staff not meeting licensure, certification, credentialing, or accreditation requirements.

C. Contractor understands and agrees that reimbursement rates paid under this Contract are established by the BH I/DD Tailored Plan.

4. THIRD PARTY REIMBURSEMENT.

A. Contractor will comply with N.C.G.S. §122C-146, which requires the BH I/DD Tailored Plan to make every reasonable effort to collect payments from third party payers.

B. Contractor is required to bill all applicable third party payers prior to billing the BH I/DD Tailored Plan. Each time a Member receives a service, Contractor shall determine if the Member has third party coverage that covers the service provided.

i. Medicaid benefits payable through the BH I/DD Tailored Plan are secondary to benefits payable by a primary payer, including Medicare, even if the primary payer states that its benefits are secondary to Medicaid benefits or otherwise limits its payments to Medicaid Members.

ii. The BH I/DD Tailored Plan makes secondary payments to supplement the primary payment if the primary payment is less than the lesser of the usual and customary charges for the service or the rate established by the BH I/DD Tailored Plan. The rate established aligns with the required rates paid by the BH I/DD Tailored Plan as well as inclusive the rate floor established by the Department.

iii. The BH I/DD Tailored Plan does not make a secondary payment if the Contractor is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.

iv. If Contractor or Member receives a reduced primary payment because of failure to file a proper claim with the primary payer, the BH I/DD Tailored Plan secondary payment may not exceed the amount that would have been payable if the primary payer had paid on the basis of a proper claim.

v. Contractor must inform the BH I/DD Tailored Plan that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

C. Contractor shall bill the BH I/DD Tailored Plan for third party co-pays and/or deductibles only as permitted by Controlling Authority.

5. UNDERPAYMENT/PAYMENTS POST APPEALS.

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

B. Upon the conclusion of any grievance, appeal or litigation that determines that BH I/DD Tailored Plan improperly failed to pay a claim or a portion of a claim to Contractor, the BH I/DD Tailored Plan shall remit the amount determined to be owed to Contractor.