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FORMATTED FOR SIGNATURES.**

MEDICAID NETWORK PARTICIPATING PROVIDER CONTRACT

NOTE: THIS AGREEMENT IS BINDING UPON EACH PARTY AT THE TIME THAT THE PARTY SIGNS THIS AGREEMENT, PROVIDED THAT THIS AGREEMENT REMAINS SUBJECT TO THE APPROVAL OF THE STATE OF NORTH CAROLINA, AND MAY BE AMENDED BY THE PARTIES TO COMPLY WITH ANY REQUIREMENTS OF THE STATE OF NORTH CAROLINA. [PROVIDER] ACKNOWLEDGES THAT THE REQUIREMENTS OF THE STATE OF NORTH CAROLINA, THE STATE CONTRACT, AND APPLICABLE LAWS AND REGULATIONS, AS AMENDED FROM TIME TO TIME, ARE INCORPORATED.

THIS MEDICAID NETWORK PARTICIPATING PROVIDER CONTRACT (“Contract”) is made and entered into by and between Alliance Health , a political subdivision of the State of North Carolina and Prepaid Health Plan operating a Tailored Plan (hereinafter referred to as “Alliance” or “Tailored Plan”), and the Provider listed below (hereinafter referred to as “Provider” or “Participating Provider”), also individually referred to as “Party” and collectively as “Parties”, for Provider’s provision of Medicaid Covered health care items and Services to Alliance’s Tailored Plan Enrollees.

Provider Legal Name	Enter Provider Name
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ARTICLE I: GENERAL TERMS AND CONDITIONS

1. CONSTRUCTION:

- a. This Contract is designed for use with a variety of Providers. Provisions specific to particular Providers are included and incorporated herein in Attachments to this Contract.
- b. The following rules of construction apply to this Contract: (i) all words used in this Contract will be construed to be of such gender or number as the circumstances require; (ii) references to specific statutes, regulations, rules or forms, include subsequent amendments or successors to them; and (iii) references to a government department or agency include any successor departments or agencies.
- c. The Paragraph headings used herein are for reference and convenience only, and shall not enter into the interpretation this Contract. Any appendices, exhibits, or schedules referred to herein or attached or to be attached hereto are incorporated to the same extent as if set forth in full herein.
- d. This Contract may be executed in two (2) or more counterparts and may be executed and transmitted by way of original signature, facsimile or electronic signature, and if so, shall be considered an original.

2. DEFINITIONS:

In addition to terms defined elsewhere in this Contract, the following capitalized terms when used in this Contract shall have the meanings set forth below. The use of the singular of any of these words, terms or

acronyms herein shall be construed to include the plural and vice versa. Any term not otherwise specified herein shall have the same definition and meaning as in the Alliance Provider Manual or N.C.G.S. § 122C-

- a. **1115 Demonstration Waiver:** As defined by Section 1115 of the Social Security Act, state demonstrations that give states additional flexibility to design and improve their programs by demonstrating and evaluating state-specific policy approaches to better serving Medicaid populations. Specifically, North Carolina's amended 1115 demonstration waiver application to the federal Centers for Medicare & Medicaid Services (CMS) focuses on the specific items of the Medicaid Managed Care transformation that require CMS waiver approval (waiver #11-W00313/4; <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf>).
- b. **1915(c) Medicaid Waiver:** refers to the two (2) North Carolina Medicaid Section 1915(c) Home and Community-Based Services (HCBS) waivers: the North Carolina Innovations waiver for individuals with Intellectual and Developmental Disabilities (I/DD) and the (Traumatic Brain Injury (TBI) waiver for individuals with a TBI in limited geographies. The Innovations and TBI waivers provide a community-based alternative to institutional care for BH I/DD Tailored Plan Members who meet medical necessity for an institutional level of care.
- c. **Amendment:** means any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an amendment.
- d. **Behavioral Health and Intellectual /Developmental Disability Tailored Plan (BH I/DD Tailored Plan or Tailored Plan):** means a capitated prepaid health plan contract under the NC Medicaid transformation 1115 demonstration waiver that meets all of the requirements of Article 4 of Chapter 108D of the North Carolina General Statutes, including the requirements pertaining to BH I/DD tailored plans.
- e. **Behavioral Health and Intellectual /Developmental Disability Tailored Plan Region (BH I/DD Tailored Plan Region or Tailored Plan Region or Region):** means the geographic portion of North Carolina as defined by the Division of Health Benefits (DHB) that is served by Alliance pursuant to contracts with the North Carolina Department of Health and Human Services (DHHS).
- f. **Benefit Plan:** The specific plan of benefits for health care coverage for Medicaid Members that is provided, sponsored or administered by Alliance directly or through its contractors, and contains the terms and conditions of a Member's coverage for Services, including exclusions and limitations, and all other provisions applicable to the coverage of such Covered Services.
- g. **Beneficiary:** An individual who is enrolled in the North Carolina Medicaid or NC Health Choice programs but who may or may not be enrolled in the Medicaid Managed Care program.
- h. **Clean Claim:** means a claim submitted to Alliance for Covered Services that is (i) received timely by Alliance, (ii) can be processed without obtaining additional information from the provider, (iii) includes all relevant information necessary to determine payor liability and to comply with applicable laws, regulations and N.C. Medicaid Program Requirements, including, but not limited to 42 C.F. R. § 447.45, (iv) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider that is under investigation for fraud or abuse.
- i. **Closed Provider Network or Closed Network:** means the network of Providers that have contracted with Alliance or its Contractors to furnish mental health, intellectual or developmental

disabilities, and substance abuse services to Members. Providers acknowledge and understand that Alliance has full authority to create and manage its Closed Provider Network.

j. **Contract:** means this Medicaid Network Participating Provider Contract between Alliance and Provider, including any and all Appendices and Attachments and contract documents, which are incorporated herein as the embodiment of the agreement between Alliance and Provider for the provision of health care services in the Alliance BH I/DD Tailored Plan Network.

k. **Contractor:** Entity contracted with Alliance through a Delegated Services Agreement to perform core Medicaid Tailored Plan Services operations.

l. **Covered Services:** means Medically Necessary health care items and Services covered under Alliance's Medicaid Benefit Plan.

m. **Credentialing Criteria:** means Alliance's criteria for the credentialing or re-credentialing of Providers.

n. **Days:** shall mean calendar days unless otherwise specified. A "business" or "working" day is a day on which Alliance is officially open for business. Unless otherwise specified within the Contract, days are tracked as Calendar Days.

o. **Department:** means the North Carolina Department of Health and Human Service (DHHS) and its Divisions, including but not limited to the Division of Health Benefits (DHB), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), and Division of Health Service Regulation (DHSR).

p. **Electronic Provider Portal Access/ User Addendum:** means the User Agreement to access Alliance's secure, web-based, electronic authorization, care coordination and billing system required to be used by Provider, attached hereto as Appendix E and incorporated herein.

q. **Electronic Visit Verification System:** means, as set forth in Section 12006 of the 21st Century Cures Act, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to (i) the type of service performed, (ii) the individual receiving the service, (iii) the date of the service, (iv) the location of service delivery, (v) the individual providing the service and (vi) the time the service begins and ends.

r. **Emergency Services:** has the same meaning as defined in 42 CFR § 422.113 and § 438.114.

s. **Encounter Data:** means encounter information, data and reports for Covered Services provided to a Member who meets the requirements for Clean Claims.

t. **Federal Health Care Program:** means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid, and CHIP.

u. **Governmental Authority:** means the United States of America, the States, or any department or agency thereof having jurisdiction over Alliance, a Provider or their respective affiliates, employees, subcontractors or agents. DHHS is a Governmental Authority as defined herein.

v. **Health System (also, Hospital System or System):** means a hospital and its designated

affiliated physicians or health care practices, as the terms Health System and Hospital System are accepted by the Department. A Health System or Hospital System includes all facilities and sites enrolled with the Department and affiliated with the System in the Department's Medicaid Management Information System and all practitioners billing through the System's National Provider Identifier(s) on the effective date of this Contract.

w. **Health System Medicaid Contract Services:** (also, "Attachment A-1") refers to the medically necessary Mental Health, Intellectual/Developmental Disability, and/or Substance Abuse Services set forth in Attachment A-1 published on the Alliance Health website at <https://www.alliancehealthplan.org/document-library/65995> that a contracted Health System Provider is eligible and qualified to provide to Alliance's Members pursuant to the terms of this Contract. Attachment A-1 is incorporated herein by reference as an essential Contract document.

u. **Ineligible Person:** means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise excluded from participating in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the System for Award Management maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128 or 1128A of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

v. **Innovations Waiver:** means the Medicaid Section 1915(c) Home and Community-Based Services (HCBS) waiver for eligible individuals with (I/DD) that Alliance operates in its Region.

w. **Law:** means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including but not limited to (a) the Social Security Act, including Titles XVII (Medicare), XIX (Medicaid) and XXI (State Children's Health Insurance Program or CHIP) and North Carolina Medicaid Waivers 1915(c) and the 1115 Demonstration Waiver, (b) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients' advance directives, (e) State laws and regulations governing third party administrators or utilization review agents, and (f) State laws and regulations governing the provision of Medicaid health care services.

x. **Local Management Entity/Managed Care Organization:** has the same meaning as in N.C.G.S. 122C-3 (20c).

y. **Medical Record:** means a single complete record, maintained by the Provider, which documents all of the treatment plans developed for, and Covered Services received by a Member.

z. **Medically Necessary or Medical Necessity:** Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

aa. **Member:** means a Medicaid beneficiary specifically enrolled in and receiving benefits

through the North Carolina Medicaid Managed Care program.

bb. **NC Medicaid Program:** means the program operated by the Department for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State Plan for Medical Assistance and the applicable policies and procedures of DHB. Participation in the Alliance Network is distinct from Enrollment in the NC Medicaid Program.

cc. **NC Tracks:** means the multi-payer Medicaid Management Information System for the NC Department of Health and Human Services. It is a condition precedent of this Contract and payment hereunder that Provider be properly enrolled in NC Tracks.

dd. **Notice:** means a written communication between the Parties delivered by trackable mail, electronic means or facsimile to the Notice Contact listed in Article I. Paragraph 14 of the Contract.

ee. **Overpayment:** means the payments a Provider receives from Alliance to which the Provider is not entitled, including but not limited to payments (a) for items and services that are not Covered Services, (b) paid in error, (c) resulting from enrollment errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) for claims paid when Alliance was the secondary payor and the Provider should have been reimbursed by the primary payor.

ff. **Participating Provider (Provider):** means an individual, entity or Health Care Provider, as that term is defined by N.C.G.S. §58-50-270(3a), that has entered into a Medicaid Network Participating Provider Contract with Alliance or with any of its Contractors for the provision of Covered Services to Alliance Members. Participating Providers must maintain a Network Participating Provider Contract with Alliance, comply with monitoring and oversight obligations, and provide consistent, timely services to Members pursuant to this Contract in order to request payment or reimbursement for those services.

gg. **Principal:** means a person with a direct or indirect ownership interest of five percent or more in Provider.

hh. **Program Requirements:** refers to collectively as the requirements of Governmental Authorities governing a Provider's participation in Alliance's provider network and rendering Covered Services to Tailored Plan Members pursuant to a Benefit Plan including, where applicable, the requirements of a contract between the Governmental Authority and Alliance.

ii. **Provider-based Care Management:** Care management where the care manager is affiliated with an AMH+ practice or Care Management Agency (CMA) and performs care management at the site of care, in the home, or in the community through in-person and other methods of interaction between Members and providers

jj. **Provider Manual:** means Alliance's most current Provider Manual, as approved by the Department, that offers information and education to providers about the Alliance Benefit Plan and Medicaid Managed Care. It sets forth Alliance's requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Alliance from time to time. An electronic version of the Provider Manual is accessible via the Alliance website or the Provider Web Portal, and in writing upon request of a Participating Provider at: <https://www.alliancehealthplan.org/providers/publications-forms-documents/>

kk. **Provider Network:** means the network of Providers that have contracted with Alliance or its Contractors for the provision of Covered Services to Alliance Members pursuant to a Medicaid Network Participating Provider Contract.

ll. **Provider Web Portal:** means an internet based portal that provides access to Program Requirements, and provider specific information. Providers may access training materials, submit appeals and grievances, and receive notices via the Provider Web Portal.

mm. **Service:** means medically necessary Covered Service(s) set forth in Attachment A that Provider is eligible and qualified to provide to Alliance's Members pursuant to the terms of this Contract.

nn. **Standard Plan:** has the same meaning as Standard Plan as defined in N.C. Gen. Stat. § 108D-1(36).

oo. **State:** whether capitalized or not, means the State of North Carolina or the Department as an agency or in its capacity as a Governmental Authority. Any references to state law, policies, procedures, regulations, controlling authority and/or other standards applicable to this Contract shall refer to North Carolina without regard to whether a Provider may have offices and/or deliver Services outside of North Carolina. Where a Provider is subject to the law, policies, procedures, regulations and/or other standards of different state(s), Provider must also adhere to authority of the State of North Carolina applicable to Services delivered under this Contract.

pp. **State Contract:** means the applicable contract or contracts between Tailored Plan and DHHS as in effect throughout the Term of this Contract pursuant to which Tailored Plan operates a managed care plan or plans in the Tailored Plan Region.

qq. **Traumatic Brain Injury Waiver (TBI Waiver):** means the Medicaid Section 1915(c) Home and Community-Based Services (HCBS) waiver for eligible individuals with traumatic brain injury (TBI) that the BH I/DD Tailored Plan operates in the geographic area covered by this Contract. The TBI Waiver may not operate in all geographic areas of the state. Contract requirements for the TBI Waiver apply for the BH I/DD Tailored Plan to the extent that the TBI Waiver is operational in its geographic area.

rr. **US DHHS:** means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services (CMS) and its Office of Inspector General (OIG).

3. **RELATIONSHIP OF THE PARTIES:** Provider enters into this Contract with Alliance for the purpose of providing medically necessary Medicaid Services to Alliance Members. 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 Provider is an independent contractor of Alliance. 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.

4. **ENTIRE AGREEMENT AND REVISIONS:** This Contract, including the Attachments and Appendices, each of which is made a part of and incorporated into this Contract, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings, whether verbal or in writing, related to the subject matter of this Contract.

5. **CONTROLLING AUTHORITY:** Provider agrees to comply with Controlling Authority and any and all applicable federal, state and local laws, rules and regulations, or orders as amended, implemented, or supplemented. Provider shall be responsible for keeping abreast of changes to Controlling Authority and to provide education and training to its staff and employees as appropriate. Provider shall develop and implement a compliance program in accordance with 42 U.S.C. § 1396a (kk)(5). This Contract is required by 42 C.F.R. §438.214 and shall be subject to the following, including any subsequent revisions or amendments thereto, (hereinafter referred to as the “Controlling Authority”):

- a. Title XIX of the Social Security Act and its implementing regulations.
- b. Applicable provisions of North Carolina General Statutes Chapters 108A, 108D and 122C.
- c. The North Carolina State Plan for Medical Assistance.
- d. The North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SA) health plan waiver authorized by the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 1915(b) of the Act, and the N.C. Home and Community Based Services Innovations waiver authorized by CMS pursuant to Section 1915(c) of the Act.
- e. 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.*
- f. All federal and state Member’s rights and confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 CFR Parts 160, 162 and 164, as further expanded by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as “ARRA” (Public Law 111-5) and any subsequent modifications thereof; the Substance Abuse Confidentiality regulations codified at 42 U.S.C. § 290dd-2 and 42 CFR Part 2; N.C.G.S. § 122C-51, *et seq.*; N.C.G.S. § 108A-80; 10A NCAC Subchapter 26B; and DMH/DD/SAS Confidentiality Rules published as APSM 45-1 (effective January 2005).
- g. Regulations concerning access to care, utilization review, clinical studies, utilization management, care management, quality management, disclosure and credentialing activities as set forth 42 CFR Parts 438, 441, 455, and 456.
- h. State licensure and certification laws, rules and regulations applicable to Provider.
- i. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. § 108A-54.2.
- j. The Alliance Provider Manual.
- k. Applicable federal and state records retention, recordkeeping and reporting rules, regulations and requirements, including but not limited to the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, effective April 1, 2009, and APSM 10-3 and all applicable revisions, amendments, and/or updates.
- l. The Americans With Disabilities Act, Titles VI and VII of the Civil Rights Act of 1964, Sections 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, or national origin, be subjected to discrimination in the provision of any services or in employment practices.
- m. The Drug Free Workplace Act of 1988.
- n. Any other applicable federal or state Laws, rules or regulations, or orders in effect at the time the service is rendered.

6. **COMPLIANCE WITH LAWS:** Provider understands that applicable State and Federal requirements and Alliance policies and procedures may be changed or updated during the term of this Contract and that those changes will apply to this Contract in the same manner as the original authority.

Alliance will post changes to the Alliance Provider Manual on the Alliance website at least thirty (30) days prior to the effective date of any changes to the Manual.

Providers shall cooperate with Alliance with respect to Alliance's compliance with Laws, accreditation and Program Requirements, including downstream requirements that are inherent to Alliance's responsibilities under Laws, accreditation or Program Requirements. Provider shall not knowingly take any action contrary to Alliance's obligations under Laws, accreditation or Program Requirements.

7. **ASSURANCE OF THE RIGHTS OF MEMBERS:** The Provider shall comply with the implementation of all policies and procedures, created by Alliance for the assurance of the rights of Members served by the Provider and all Laws, rules and/or regulations including Member grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and Article 3, Part 1 of the North Carolina General Statutes Chapter 122C and rules promulgated thereunder. Provider's compliance with Member grievance, appeal and fair hearing procedures shall include Provider's cooperation with Member and Alliance, providing information, records or documents requested by Alliance and participating in the grievance/appeal process when applicable.

Provider shall protect the confidentiality of any and all Members and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing Services hereunder, except as authorized by the individual, his legally responsible person, or as otherwise permitted or required by law. The Provider shall, in addition, meet all confidentiality requirements promulgated by any applicable governmental authority. Further, Provider shall adhere to the Confidentiality laws set forth in N.C.G.S. Chapter 122C Article 3 Part 1.

8. **NON-DISCRIMINATION - EQUITABLE TREATMENT OF MEMBERS:** Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment or participation in Benefit Plan, genetic information or ethnicity. Further, Provider agrees that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) Members who obtain covered services shall not be subject to treatment or bias that does not affirm the member's identifying orientation.

Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements. Provider shall not bill any Member for Covered Services. This provision shall not prohibit Provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as Provider has notified Member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the Member elects to receive the service with that understanding.

Providers may freely communicate with Members about their treatment regardless of Benefit Plan coverage limitations. Alliance does not dictate or control clinical decisions respecting a Member's medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Alliance. Nothing in this Contract shall be interpreted to permit interference by Alliance with communications between a Provider and a Member regarding the Member's medical condition or available treatment options.

9. **TERM:** The Term of this Contract shall begin on the XXX day of Month, 2022 (the "Effective Date"), and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term, unless and until the Contract is terminated in accordance with the terms and conditions herein. Notwithstanding the above, the term of this Contract, including any renewal, may be limited to comply with Laws or an order by or Alliance's contract with a Governmental Authority.

10. **CHOICE OF LAW/ MANDATORY FORUM SELECTION:** This Contract shall be governed by and interpreted and enforced in accordance with the laws of the State of North Carolina, except where Federal law applies, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate State or Federal court located in Wake County, North Carolina in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with this Agreement. Where applicable, a Provider shall fully exhaust Alliance's reconsideration procedure as set forth in the Provider Manual before seeking any other remedy.

11. **NON-WAIVER:** No covenant, condition, or undertaking contained in the Contract may be waived except by the written agreement 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, the other Party shall be entitled to invoke any remedy available under the Contract, despite any such forbearance or indulgence. A waiver by a Party of a breach or failure to perform this Contract shall not constitute a waiver of any subsequent breach or failure.

12. **DISPUTE RESOLUTION:** The Provider may request reconsideration of an administrative action or sanction imposed under this Contract or file a grievance in other matters as outlined in the Provider Manual and as set forth herein. A Network Participating Provider has the right to request reconsideration of certain actions taken by Alliance, including:

- a. Program Integrity related findings or activities;
- b. Finding of fraud, waste, or abuse by the BH I/DD Tailored Plan;
- c. Finding of or recovery of an overpayment by the BH I/DD Tailored Plan;
- d. Withhold or suspension of a payment related to fraud, waste, or abuse concerns;
- e. Termination of, or determination not to renew, an existing contract for Local Health Department (LHD) care/case management services;
- f. Determination to de-certify an AMH+ or CMA; and
- g. Violation of terms between the BH I/DD Tailored Plan and Provider.

12. **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.

13. **NOTICE:** Any Notice to be given under this Contract including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be in writing and addressed to the receiving Party as its Notice Contact is designated below, or at such other address as the Party may designate by prior written Notice to the other Party. Means for sending all notices provided under this Contract shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by Alliance and the Provider. :

Enter Provider Name	Alliance Health
Enter Notice Contact Name	ATTN: CONTRACTS
Enter Title	5200 West Paramount Parkway, Suite
Enter Mailing Address	200

Enter City, State, Zip Code	Morrisville, NC 27560 Contracts@AllianceHealthPlan.org
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14. **NOTICE OF CHANGE:** Provider agrees, understands and acknowledges that services delivered under this Contract are site and Service specific. Providers are required to notify Alliance when organizational changes occur, including but not limited to changes in ownership, personnel, address, and name /or and contact information. Providers are required to follow the Notice of Change requirements for contained in the Provider Manual utilizing the Alliance Notice of Change Form available on the Alliance website. Alliance will not process retroactive changes, and the effective date of any change will be no sooner than the effective date on the Notice of Change or the effective date shown in NC Tracks, whichever is later. Any changes must be reported in writing to Alliance pursuant to the Alliance Provider Manual.

15. **TERMINATION:** Alliance reserves the right, in its sole discretion, at any time during the term of the Contract to remove one or more services provided by Provider at one or more identified Site Addresses from the Contract for no reason or any reason, including, but not limited to, Network provider capacity maintenance, Member health and safety, Provider not meeting Member demand and/or needs, Provider quality management, or any other reason Alliance deems necessary to manage its Network of Providers. Except for circumstances requiring immediate termination and/or suspension as set forth in subsection f. of this paragraph, Alliance shall provide thirty (30) days written notice prior to the removal of a Service. Termination of this Contract in whole or part under the terms set forth below shall not form the basis of any claim for loss of anticipated profits by either Party. The rights and remedies provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract. Termination of this Contract in whole or part is not deemed a reduction, denial, termination, or suspension of a Provider's participation in or disenrollment from the NC Medicaid Program

a. **Non-Appropriation.** Funds used for Provider payments are government funds. Either Party may terminate the Contract or individual Services immediately if Federal, State or local funds allocated to Alliance are reduced, revoked or terminated in a manner beyond the control of the Alliance for any part of the Contract period. In such event, Alliance will reimburse Provider for timely submitted Clean Claims for Services provided which were authorized as necessary by the Alliance prior to the date of such change in Federal, State or local funding.

b. **Mutual Agreement.** This Contract may be terminated in whole or part at any time upon mutual consent of both Parties with mutually agreed upon Notice to Members or after thirty (30) days upon notice of termination by one of the contracting Parties. Alliance may withhold payment or impose other penalties or sanctions (up to and including termination of any other Contract(s) between Alliance and Provider) in the event that Provider fails to give at least thirty (30) days' notice of termination.

c. **Termination for Convenience.** This Contract may be terminated in whole or part after thirty (30) days' written Notice of termination by one of the contracting Parties.

d. **Termination for Cause.** Alliance may terminate the Contract in whole or part with cause upon thirty (30) days' written notice to Provider. Cause for termination of the Contract may include, but is not limited to:

- i. Failure to implement or provide functions or services as specified in this Contract. Failure to provide timely, complete and accurate documentation of services as required by this Contract may also lead to withholding of funds or termination of the Contract; and/or
- ii. The conduct of Provider or Provider's employees or agents or the standard of services provided threatens to place the health or safety of any Member in jeopardy. Conduct of Provider's employee(s) or agent(s) that threatens to place the health or safety of any Member in jeopardy shall not constitute grounds for termination of the entire Contract provided Provider takes appropriate action toward said employee(s) or agent(s).

Alliance maintains its right to terminate this Contract should Provider fail to take appropriate action toward employees or agents whose conduct threatens to place the health or safety of any Member in jeopardy; and/or

- iii. Failure of Provider to cooperate with any investigation authorized by Controlling Authority and deemed necessary by Alliance in regard to Alliance Members; and/or
 - iv. Failure of Provider to reimburse Alliance for final overpayments identified by Alliance or failure to comply with payment plans established by Alliance as outlined in Article IV, Billing and Reimbursement; and/or
 - v. Failure of Provider to accurately maintain enrollment in NC Tracks; and/or
 - vi. Failure of Provider to meet or maintain NC Medicaid Program Requirements
 - vii. Any other material breach of this Contract.
- e. **Notice of Termination for Cause.** Written notice to Terminate for Cause shall include:
- i. The reason for decision to terminate;
 - ii. The effective date of termination;
 - iii. The Provider's right to Appeal the decision; and
 - iv. How to request an Appeal.
- f. **Immediate Terminations and Suspensions of Contract.** Provider acknowledges and agrees that Alliance shall terminate all or a portion of this Contract immediately, without prior written Notice or opportunity to cure in the following circumstances:
- i. Loss of Provider's required facility or professional licensure;
 - ii. Failure to meet or maintain Alliance's credentialing or re-credentialing standards;
 - iii. Provider has been debarred, suspended, terminated, or is otherwise lawfully prohibited from participation in any federal or state government procurement activity;
 - iv. The final substantiation and determination by The Department of Medicaid fraud and/or abuse.
 - v. In accordance with 42 CFR § 455.416:
 - a) When any person with a five percent (5%) or greater direct or indirect ownership interest in the Provider agency does not submit timely and accurate information and cooperate with any screening methods required under this Contract;
 - b) When any person with a five percent (5%) or greater direct or indirect ownership interest in the Provider agency has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years, unless Alliance determines that termination is not in the best interests of the Alliance's Provider Network;
 - c) If Provider is terminated, under title XVIII of the Social Security Act or under the Medicaid Program or Children's Health Insurance Program of any State;
 - d) If the Provider or a person with an ownership or control interest or who is an agent or managing employee of the Provider agency fails to submit timely or accurate information, unless Alliance determines that termination is not in the best interests of the Alliance's Provider Network;
 - e) If the Provider, or any person with a five percent (5%) or greater direct or indirect ownership interest in the Provider agency fails to submit sets of fingerprints in the form and manner required by DHB within thirty (30) calendar days of request, unless Alliance determines that termination is not in the best interests of the Alliance's Provider Network; or
 - f) If the Provider fails to permit access to Provider locations for any site visits required under 42 CFR § 455.432, unless Alliance determines that termination is not in the best interests of the Alliance's Provider Network.

Provider further acknowledges and agrees that Alliance may also immediately suspend all or a portion of this Contract, without prior written Notice or opportunity to cure in the

following circumstances:

- vi. Upon a confirmed finding of fraud, waste, or abuse by Provider by the Department or the Medicaid Investigations Division (MID) of the North Carolina Department of Justice;
- vii. The Department's finding of a credible allegation of fraud, waste, or abuse; or
- viii. A determination of serious quality of care concerns by Alliance or the Department.
- ix. Upon termination of Alliance's BH I/DD Tailored Plan contract with the Department;

The Parties understand, acknowledge and agree that enrollment in the NC Medicaid Program is distinct from enrollment in the Alliance Provider Network, that Alliance has the authority to terminate Provider's enrollment in its Provider Network, and that Alliance has *no* authority to suspend or terminate a Provider's enrollment in the NC Medicaid Program.

Nothing in this Section shall preclude Alliance from terminating this Contract, for any other reason, in whole or in part, or as otherwise authorized by law or this Contract.

- g. **Sanctions.** If the Provider fails to fulfill its duties and obligations pursuant to this Contract, Alliance may impose Sanctions as set forth in the Provider Manual. Sanctions imposed by Alliance may be progressive or cumulative in order to address the specific area(s) of the Contract that are not being fulfilled by the Provider.
- h. **Opportunity to Cure Not Required.** Alliance may, but is not required to, offer Provider the opportunity to cure by providing Provider with written Notice of a material breach specifying the breach and requiring it to be remedied within, in the absence of greater or lesser specification of time, seven (7) calendar days from the date of the Notice; and if the breach is not timely cured, terminate the Contract upon written Notice of Termination. Provider shall not be entitled to any form of injunctive relief if this Contract is terminated by Alliance in whole or in part.

16. **EFFECT OF TERMINATION:**

Alliance reserves the right to approve any Provider's participation in the Alliance Network or to terminate or suspend all or a portion of Provider's Contract. The obligations of both Parties under this Contract shall continue following termination only as to the terms and conditions that by their nature are intended to survive. In the event of termination for any reason hereunder, the Members served shall be of highest priority. The Parties shall work diligently together to provide for all necessary transition services, pursuant to the procedures set forth in the Provider Manual.

- a. In the event Alliance terminates this Contract in whole or in part for cause, Alliance may: (1) deduct any and all expenses incurred by Alliance for damages caused by the Provider's breach; and/or (2) pursue any of its remedies at law or in equity, or both, including damages and specific performance.
- b. 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 Provider and the Alliance 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.
- c. 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.
- d. In the event that Alliance terminates this Contract due to BH I/DD Tailored Plan's insolvency:
 - i. Administrative duties and records will be transferred to the successor organization, appointed by the Secretary of the Department of Health and Human Services as set forth in NC General Statute §122C-125, and in compliance with the Records Management and Documentation Manual for LME-MCOs (ASPM 45-2).

- ii. When inpatient care is ongoing, Provider shall continue to render inpatient care pursuant to the continuity of care provisions in section below g. until the patient is ready for discharge. If Alliance provides or arranges for the delivery of health care services on a prepaid basis, payment for Member's inpatient care shall be continued until the Member is ready for discharge.
- e. In the event of termination the Provider shall submit all claims or registrations of putative Members within sixty (60) days of the date of termination.
- f. In the event of any audit or investigation described in Article II, both Parties shall settle their debts and claims within thirty (30) days of 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 advance payments have been made for services not provided as of the date of termination, the Provider shall promptly refund all excess funds paid within the above-referenced thirty (30) days.
- g. **Continuity of Care.** Provider shall comply with Controlling Authority and provide Notice to Alliance with respect to the closing of a facility or site. Provider shall develop a transition plan for each Member prior to being discharged and provide Alliance with a list of Enrollees with appointments scheduled with Provider at the time of termination or closure.

To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Contract for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Alliance for the transition of Members to other Participating Providers. The terms and conditions of this Contract shall apply to any such post expiration or termination activities. The continuity of care provisions in this Contract shall survive expiration or termination of this Contract.
- h. Prior Authorization is not a guarantee of payment and does not survive termination of this Contract.

17. **RECORDS FOLLOWING TERMINATION OR CLOSURE:** If the Provider's contract is terminated or expires or if the Provider closes its business in Alliance's Region (but continues to have operations elsewhere in the State), the Provider must within 30 days of termination/expiration/closure either provide copies of Medical records of Members to Alliance or submit a plan for maintenance and storage of all records for approval by the Alliance. Alliance has the sole discretion to approve or disapprove such plan.

Abandonment of records is a serious HIPAA and contractual violation and can result in sanctions and financial penalties. The following steps are required of Alliance as soon as Alliance is made aware of the abandonment of any Medical records of Members served pursuant to this Contract:

- a. Alliance is to notify the DHB Office of Compliance and Program Integrity (or other applicable Department Division based on funding source and licensure) about the abandonment;
- b. Alliance is to inform the Provider of the report to the Department regarding the abandonment via trackable mail; and
- c. Alliance is to use best efforts to secure the records and complete an inventory log of the records.

18. **NON-EXCLUSIVE ARRANGEMENT:** Alliance has the right to enter into a Contract with any other provider for Covered Services. Provider shall have the right to enter into other Contracts with any other BH IDD Tailored Plan or third Party payers to provide services. This is not an exclusive agreement

for either Party, and there is no guarantee that Alliance will participate in any particular Program, or that any particular Benefit Plan will remain in effect.

19. **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 Alliance, Provider or the Department.

20. **NOT RESPONSIBLE FOR EXPENSES INCURRED**: Alliance shall not be liable to Provider for any expenses paid or incurred by Provider, unless as specifically agreed upon in writing and signed by both Parties.

21. **EQUIPMENT**: Provider shall supply, at its sole expense, all equipment, tools, materials, and/or supplies required to provide Services hereunder, unless otherwise agreed in writing.

22. **ASSIGNMENT/SUBCONTRACTING**: Provider's duties and obligations under this Contract shall not be assigned, delegated, or transferred without the prior written consent of Alliance. Provider may not assign or subcontract duties, rights, or interests under this Contract unless Alliance provides prior written consent. Both Parties shall ensure that any subcontractors performing any of the obligations of this Contract shall meet all requirements of this Contract and the standards of Alliance's National Accrediting Bodies. Alliance shall notify Provider in writing of any duties or obligations that are to be delegated or transferred before the delegation or transfer. Provider shall follow Alliance's procedures with respect to subcontractors.

23. **NO PRESUMPTION AGAINST DRAFTER**: If any ambiguity or question of intent or interpretation arises, this Contract shall be construed as if drafted jointly by the Parties, and no presumption or burden of proof shall arise favoring or disfavoring any Party by virtue of the authorship of any of the provisions of this Contract.

24. **GOVERNMENTAL RESTRICTIONS**: Should Alliance notify the Provider that any program or activity in the scope of work under this Contract is no longer authorized by law (e.g., vacated by a court of law, CMS withdraws federal authority, or subject of a legislative repeal), the Provider shall do no work on that part of the Contract after the effective date identified in the Notice. Alliance shall remove costs that are specific to any program or activity under the Contract that is no longer authorized by law. If the Provider provides Services no longer authorized by law after the effective date identified in the notice, the Provider shall not be paid for that work. If Alliance paid the Provider in advance to provide Services no longer authorized by law and under the terms of this Contract the work was to be performed *after* the effective date identified in the notice, the payment for those Services shall be returned to Alliance. However, if the Provider provided a service no longer authorized by law *prior* to the effective date identified in the Notice, and Alliance included the cost of performing those services in its payments to the Provider, the Provider may keep the payment for those services even if the payment was made after the effective date identified in the Notice.

25. **SURVIVAL**: Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

ARTICLE II: OBLIGATIONS OF THE PARTICIPATING PROVIDER

1. Provider is required to participate in Alliance's utilization management, care management, quality management, access, finance, qualification/accreditation, credentialing, and compliance processes as

well as comply with all Network requirements for reporting, inspections, monitoring, and Member choice requirements as set forth herein and in the Provider Manual.

2. **SERVICES:**

a. **Delivery of Services.** Provider agrees to provide the Medically Necessary Service(s) to Members set forth in Attachment A at the approved sites, pursuant to the terms of this Contract. All Services shall be rendered in a manner consistent with Clinical Practice Guidelines and with applicable Controlling Authority. The Parties understand and agree that there is no guarantee of referrals provided under this Contract and that Alliance is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider. Provider is required to serve Members within sixty (60) calendar days from the date of execution of this Contract. If Provider has not accepted and delivered services to Members within sixty (60) calendar days from the date of execution of this Contract or within sixty (60) calendar days prior to the expiration of the term of this Contract, the Contract or the Services not rendered may be terminated.

b. **For Providers of Care Management Services.** For Local Health Departments (LHD) providing Care Management Services, AMH+ Practices, CMAs, and Providers of prenatal, perinatal and postpartum care, Provider acknowledges and agrees to comply with the service-specific Program Requirements set forth in the applicable Contract Attachments, incorporated herein by reference and to with comply with Department Policy as published and revised by NC DHHS. Contracted LHDs shall also be required to conduct Refugee Health Assessments as outlined in NC Medicaid Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.

c. **Outpatient Commitment.** Providers of Services provided under Outpatient Commitment to a Member are required to notify Alliance of the Outpatient Commitment order upon receipt or notice of Outpatient Commitment.

d. **Primary Care Providers.** All In-Network Primary Care Providers must perform EPSDT (Early and Periodic Screening, Diagnostic and Treatment) screening for Alliance members less than twenty-one (21) years of age.

3. **PROVIDER ACCESSIBILITY:**

a. **Interpreting and Translation Services.** Provider must make language interpretation available by telephone and/or in person enabling Members to communicate with Provider. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder. Provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member. The Provider must ensure the Provider's staff is trained to appropriately communicate with patients with various types of hearing loss. Provider shall report to Alliance in a format and frequency to be determined by Alliance, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

b. **Hours of Operation.** Provider shall make Services covered under this Contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary, and/or in accordance with the applicable Clinical Coverage Policy, and offer hours of operation to Alliance Members comparable to Medicaid Direct hours, if applicable, and that are no less than the hours offered to privately insured individuals, and Provider must arrange for call coverage or other back-up to provide access to Services in accordance with Alliance's Standards for Provider Accessibility, as set forth herein and in the Provider Manual.

b. c

d. **No Reject Policy.** Provider shall have a “no-reject policy” for Members within capacity and parameters of their competencies. Provider agrees to accept all referrals meeting criteria for services they provide when there is available capacity.

4. **CARE COORDINATION:** Upon request by Alliance, Provider shall designate qualified care coordination staff to participate in interdisciplinary team meetings facilitated by Alliance that involve Member(s) served under this Contract.

a. Provider shall provide information pertinent to the development of an Individual Service Plan (ISP) for persons with Intellectual or other Developmental Disabilities, and a Person Centered Plan (PCP) for persons with Mental Health or Substance Use Disorder, or shall directly participate in the planning process.

b. Provider shall be responsible for the development of treatment and/or supports strategies to address assigned areas of responsibility from the PCP or ISP.

5. **CULTURAL COMPETENCE:** The Provider is required to develop a Cultural Competence Plan and is encouraged to participate in the Alliance Cultural Competency Plan. The Provider’s Cultural Competence Plan should be consistent with Alliance’s most current Cultural Competency Plan, posted at www.AllianceHealthPlan.org. The Provider shall develop procedures for the implementation of systems to evaluate and/or measure adherence to their Cultural Competence Plan, ensure that all staff are trained, and have training available for review by Alliance’s Provider Network Department. Cultural competency shall be achieved within the strictures of State and Federal laws, which require equal opportunity in employment and bar illegal employment discrimination on the grounds of race, gender, religion, sexual orientation, gender identity, national origin or disability.

6. **DISCLOSURE:** Provider shall make those disclosures to Alliance as are required to be made to DHB pursuant to 42 C.F.R. § 455.104 and 106 and are required by Alliance’s accrediting bodies and the Provider Manual. Alliance will share accrediting body requirements with Provider upon request.

Federal Law prohibits Alliance from contracting with Ineligible Persons, therefore this Contract shall be null and void if Alliance determines that Provider was an Ineligible Person at the execution of this Contract. Provider warrants and represents as of the Effective Date and throughout the term of the Contract and the duration of post expiration or termination transition activities described in this Contract, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Contract is an Ineligible Person

7. **LICENSES, ACCREDITATIONS, CREDENTIALING AND QUALIFICATIONS:**

a. Provider shall maintain all licenses, certifications, accreditations and registrations required for its facilities and staff providing services under the Contract as are required by Controlling Authority and that are sufficient to meet Alliance’s network participation requirements pursuant to Alliance’s Credentialing and Re-credentialing Policy (the Credentialing and Re-credentialing Policy is subject to amendment based upon Department review and approval, while awaiting approval of its Policy by the Department). Within five (5) days of receipt by Provider of notice of any sanction by any applicable licensing board, certification or registration agency, or accrediting body that affects the ability of Provider to bill Alliance for services, the Provider shall notify Alliance in writing.

b. Provider must notify Alliance of any changes in the status of any information relating to Provider’s professional credentials.

c. Provider must be enrolled as a Medicaid provider and active in NC Tracks and satisfy the requirements of 42 C.F.R. §455.410, and is subject to termination of this Contract if such enrollment is not maintained.

d. Provider certifies that at the time of execution of this Contract, that neither Provider, nor any of its staff or employees, or principals is excluded from participation, suspended or debarred by any applicable governmental authority from conducting any business or activities contemplated by this Contract whether under current legal name, DBA or any additional name or former name, including the current or former name of a division, department, program or subsidiary. Within five (5) business days of notification of exclusion of Provider or any of its principals, staff or employees by the U.S. Office of Inspector General, CMS or any State Medicaid program, Provider shall notify Alliance of the exclusion and its plan for compliance.

e. Provider must complete re-credentialing pursuant to Alliance's Credentialing Criteria prior to contract renewal but, in any event, no less than the following time periods:

- i. During the Provider Credentialing Transition Period, no less frequently than every five (5) years;
- ii. After Provider Credentialing Transition Period, no less frequently than every three (3) years.

Failure to meet re-credentialing standards shall be deemed a material breach of this contract and shall result in the termination of this Contract.

f. Provider shall secure and maintain for themselves and their employees commercial general liability and professional liability insurance coverage for claims arising out of events occurring throughout the term of this Contract and any post-expiration or post-termination activities under this Contract in an amount acceptable to Alliance and sufficient to meet worker's compensation coverages as required by applicable State Law. Provider shall notify Alliance on a timely basis of any subsequent changes in status of coverage, as set forth in Appendix D, incorporated herein by reference. Provider shall provide Alliance upon request with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph and shall provide Alliance with no less than thirty (30) days advance written notice of any modification, cancellation or termination of their insurance.

g. The Provider shall not bill Alliance and Alliance will not pay:

- i. For any Services provided by Provider during any period of revocation or suspension of required licensure or accreditation of the Provider's approved site or facility;
- ii. For any Services provided by a member of the Provider's staff during any period of revocation or suspension of the staff member's required certification, licensure, or credentialing.
- iii. For any services provided by non-credentialed staff or staff not meeting requirements as specified by this Contract, or as specified in the NC Medicaid Plan Clinical Coverage Policies, Alliance Provider Manual, or Mental Health, Developmental Disabilities, and Substance Abuse Service Definitions or other applicable Controlling Authority.

h. Provider certifies that at the time of execution of this Contract, neither Provider, nor any of its staff, Principals, or employees, is excluded from participation in Federal Health Care Programs under Section 1128 of the Social Security Act and/or 42 CFR Part 1001. Within five (5) business days of notification of exclusion or termination of Provider or any of its staff or employees by the U.S. Office of Inspector General, CMS or any State Medicaid program, Provider shall notify the Alliance of the exclusion or termination and its plan for compliance.

i. Provider, upon written request by Alliance, shall provide written proof of Provider accreditation. Any changes to Provider accreditation shall be immediately reported to Alliance.

8. **EVENT REPORTING AND ABUSE/ NEGLECT/ EXPLOITATION:**

a. Provider shall use best efforts to ensure that Member(s) are not abused, neglected or exploited while in its care.

b. The Provider shall report all events or instances involving abuse, neglect or exploitation of Members as required by Controlling Authority.

c. The Provider shall not use restrictive interventions except as specifically permitted by the individual Member's treatment/habilitation plan or on an emergency basis in accordance with 10A NCAC 27E.

d. Provider shall timely report and comply with applicable Member incident, critical incident and death reporting Laws, regulations and policies and event reporting requirements of Provider's and Alliance's national accreditation organizations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of the DHHS. Specifically, Providers are required to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602, in the NC Incident Response Improvement System.

e. Alliance shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error and to ensure compliance with Controlling Authority by the Provider. The Provider shall cooperate fully with all such investigative efforts. Alliance will provide the Provider a written summary of its findings within thirty (30) days. During such an investigation, if any issues are cited as out of compliance with this Contract or applicable federal or state Laws, rules or regulations, the Provider may be required to document and implement a plan of correction. Provider may request reconsideration of a determination that claims were paid in error as outlined in the Provider Manual.

9. **UTILIZATION MANAGEMENT:** The Provider shall comply with the Alliance's Utilization Management 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 I/DD Tailored Plan. The Provider shall provide the Alliance with all necessary clinical information for the Alliance's utilization management process. Provider shall also comply with Alliance's quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the Provider or interfere with the Provider's ability to provide information or assistance to their patients.

10. **AUDITS, ACCESS AND DOCUMENTATION REQUIREMENTS:**

a. **Oversight Authority:** Provider explicitly acknowledges the authority of US DHHS, including the OIG, CMS, The Department and any of its Divisions, Alliance, and agents of these entities to inspect, monitor and audit Services performed under this Contract and the authority of the Department, Alliance and other State or Federal officials to inspect and audit Provider's financial records.

In accordance with 42 CFR §§ 420.300 – 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, HHS, and their duly authorized representative shall have access to Provider's books, documents, and records until the expiration of four (4) years after the Services are furnished under the contract.

Provider acknowledges that it is subject to audits, investigations, evaluations and post-payment reviews conducted by these entities, including, but not limited to audits and evaluations conducted by Alliance pursuant to 42 C.F.R. §2.53 involving Substance Use Disorder Services and records. Where records are subject to the provisions of 42 CFR § 2.53(b), Alliance agrees, in compliance with applicable Law, to maintain patient identifying information in accordance with the security requirements provided in 42 CFR § 2.16; destroy all patient identifying information upon completion of the audit or evaluation; and when applicable, comply with the limitations on disclosure and use as required by 42 CFR § 2.53 (d).

For all Services being provided pursuant to this Contract, Alliance shall have the right to inspect, examine, and make copies of any and all books, financial documents, accounts, invoices, records of staff who delivered or supervised the delivery of Services to Members, Members' clinical records, and any other clinical or financial items or documents related to the claims submitted for the delivery of Services to Members that Alliance deems necessary to ensure compliance with the Contract.

Provider agrees to cooperate with Alliance in its Oversight and Program Integrity activities and shall take such corrective action as is necessary to comply with State and Federal law and any Accreditation Standards. Provider further agrees to provide timely, accurate, and appropriate data and information to enable Alliance to fulfill applicable accrediting organizations' and Federal and State regulatory filing requirements, provided the disclosure of such information is consistent with applicable State and Federal laws regarding confidentiality. Oversight and Program Integrity activities, including on-site inspections and investigations may occur at any time and do not have to be arranged in advance with Provider.

b. **Medical Records.** Providers shall maintain Member medical records in accordance with 42 CFR §438.208(b)(5) and shall:

- i. Maintain confidentiality of Member medical records and personal information and other health records as required by Law, including without limitation, the Health Insurance Portability and Accountability Act;
- ii. Maintain adequate medical and other health records according to industry and Alliance's standards;
- iii. Make copies of such records available to Alliance and the Department in conjunction with Department's regulation of the BH IDD Tailored Plan. Such records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party; and
- iv. Adhere to the applicable state and federal record retention schedules for each Member served, either in original paper copy or an electronic/digital copy.

Provider shall maintain all documentation and records supporting Member's medical necessity for the Services and shall provide it upon request by Alliance for Program Integrity activities, including but not limited to audits, investigations or post-payment reviews. Alliance may, but is not required to, grant additional time to respond for good cause shown and depending upon the size and scope of the request.

c. **Access to Provider Records.** Provider agrees to provide Alliance access to all books, records, and documents maintained under the Contract during normal business hours so that Alliance may perform its audit obligations, provided that any such access shall be consistent with applicable State and Federal laws and regulations. Provider and Alliance agree that all such documents shall be kept confidential, consistent with applicable State and Federal laws and regulations and Controlling Authority. Provider further agrees that surveys, reviews and/or audits performed by accrediting or regulatory authorities of Provider utilized to confirm operational compliance of or require corrective action by Provider shall be provided to Alliance upon Provider's receipt.

d. **Provider Maintenance of Records.** Provider shall maintain all information and records reviewed or created in the performance of its duties under this Contract pursuant to the requirements of Alliance, Alliance's National Accrediting Body, and in accordance with applicable Controlling Authority. Documentation must support at a minimum the billing diagnosis, the number of units provided and billed, and the standards of the billing code. Provider's obligations to maintain records under this Paragraph shall continue following termination of the Contract.

Provider agrees to maintain necessary records and accounting 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.

Provider 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 Members as required by Controlling Authority. When an audit is in progress or audit findings are unresolved, records shall be kept minimally until all issues are finally resolved.

Provider shall provide specifically denominated clinical or encounter information required by Alliance to meet State and Federal monitoring requirements upon request, except that Alliance may grant additional time to respond for good cause shown and depending upon the size and scope of the request.

e. **Paid Claims Audits.** At a minimum of once every two (2) years, the Provider will participate in an audit of paid claims conducted by Alliance. Any paid claims determined to be out of compliance with Controlling Authority shall require a repayment to Alliance as required by Controlling Authority, subject to all of Participating Provider's right of appeal. Any underpayments to Provider shall require payment by the Alliance. The Provider will receive written documentation of findings within thirty (30) days following the audit. Based upon results of the audit the Provider 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 Alliance as required by Controlling Authority.

Provider agrees that Alliance may use statistically valid sampling and extrapolate audit results in accordance with Controlling Authority.

f. **Data Requests.** Provider shall use best efforts to provide data to Alliance in the implementation of any studies or improvement projects required of Alliance by the Department. Provider and Alliance will mutually agree upon the data to be provided and the format and time frame for provision of the data.

Provider may satisfy any request for information by either paper or electronic/digital means. The requirements of this Contract regarding Records, access, and audit shall survive expiration or termination of this Contract.

11. **FRAUD, ABUSE, OVER UTILIZATION AND FINAL OVERPAYMENTS, ASSESSMENTS OR FINES:**

a. Provider understands that whenever Alliance receives an allegation of fraud, abuse, overutilization or questionable billing practice(s), Alliance is required to provide the NC Medicaid with the provider name, type of provider, source of the complaint, and approximate dollars involved. Provider understands that the Medicaid Investigations Division of the North Carolina Attorney General's Office or DHB, at their discretion, may conduct preliminary or full investigations to evaluate the reported fraud, abuse, over utilization or questionable billing practice(s) 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 Provider never rendered or for which documentation is absent or inadequate.

b. If Alliance determines Provider has failed to comply with Controlling Authority and has been reimbursed for a claim or a portion of a claim that Alliance determines should be disallowed or is the result of an error or omission, the claim shall be recouped as set forth in the Provider Manual.

c. If Alliance determines Provider has been paid for a claim that was fraudulently billed to Alliance, Alliance may provide thirty (30) days' Notice to the Provider of the intent to recoup funds. Such Notice shall identify the Member(s) name and date(s) of service in question, the specific

determination made by Alliance as to each claim, and the requested amount of repayment due to Alliance. Provider shall have thirty (30) days from date of such notification to either request reconsideration in accordance with the Alliance Provider Manual or to remit the invoiced amount.

d. Provider understands and agrees that self-audits are encouraged by Alliance.

12. **FEDERALLY REQUIRED CERTIFICATIONS:** The Provider shall execute and comply with the attached federally required certifications, which shall be incorporated herein in Appendix A as follows:

- a. Environmental Tobacco Smoke – Certification for Contracts, Grants, Loans and Cooperative Agreements,
- b. Lobbying – Certification for Contracts, Grants, Loans and Cooperative Agreements,
- c. Drug-Free Workplace Requirements, and
- d. Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions.

13. **MEMBER GRIEVANCES:**

- a. The Provider shall address all clinical concerns of the Member as related to the clinical Services provided to the Member pursuant to this Contract. Provider shall refer any unresolved concerns or requests for Services or provider change to the Alliance. The Provider shall have in place a Complaint and Grievance Process that is documented in written policy or procedures, and shall ensure that said process is accessible to all Members and that said process operates in a fair and impartial fashion.
- b. Alliance may receive complaints directly that involve the Provider. If a complaint is received by Alliance, State rules and regulations regarding the investigation and/or mediation of complaints will be followed. Based on the nature of the complaint, Alliance may choose to investigate the complaint, as authorized by Controlling Authority, in order to determine its validity. Provider is required to cooperate fully with all investigative requests as required by Controlling Authority.
- c. Alliance will maintain documentation on all follow up and findings of any complaint investigation. The Provider will be provided a written summary of Alliance's findings.
- d. During an investigation, if any issues are cited as out of compliance with this Contract or Controlling Authority, the Provider may be required to document and implement a plan of correction as required by Controlling Authority. The Provider will maintain a system to receive and respond timely to complaints received regarding the Provider. The Provider will maintain documentation on the complaint to include, at a minimum, date received, points of complaint, resolution/follow up provided, and date complaint resolved and will provide this documentation to Alliance upon request.

14. **CONTINUITY OF CARE AND ALLIANCE MEMBER CARE MONITORING:**

- a. Continuity of care is expected for all Recipients served under this Contract. Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall participate in team meetings and/or community collaborations and communicate regularly with other Providers regarding mutual cases. A pattern of failure to coordinate services in a timely manner, without demonstrated corrections may be deemed a material breach of this Contract and result in Contract termination for cause.
- b. Provider shall provide information pertinent to the development of an Individual Service Plan (ISP) for persons with Intellectual or other Developmental Disabilities, and a Person Centered Plan (PCP) for persons with Mental Health or Substance Use Disorder, or shall directly participate in the planning process. Provider shall also allow appropriately credentialed Alliance staff direct access to any Member, if requested by Member, determined to be clinically appropriate by the Member's treating Provider, and requested in advance by Alliance.
- c. Providers of Residential Substance Use Disorder treatment services are required to provide

medication assisted treatment (MAT) on-site or refer the Member to an in-network MAT Provider.

b. Provider shall coordinate the discharge of Members with Alliance to ensure that appropriate post-discharge services are arranged and to link Member with other qualified providers or community assistance for continuity of care. For purposes of this Contract, discharge is considered any termination of service from the Provider, whether initiated by the Provider, the Member, Alliance, or the Department. The Provider shall notify Alliance of termination of service within seven (7) days of the termination or planned discharge. Provider shall endeavor to provide at least twenty-four (24) hours prior notice to Alliance of the intended date and time of any discharge of a Member. Provider shall work and cooperate with the Alliance on coordination of care for any continuing services.

c. Provider must notify Alliance of any Member discharged from a high acuity clinical setting.

d. Alliance understands the importance of Member-Provider matching and that problems or incompatibilities can arise in the therapeutic relationship. Nevertheless, Provider shall, with the consent of the Member, collaborate with Member, Member's family members, and Alliance to assure continuity of care and that there is no disruption of service. Alliance will work collaboratively with the Provider to resolve any problem(s) of continuity of care or in transferring the Member to another provider.

15. **PROPRIETARY INFORMATION AND INTELLECTUAL PROPERTY:** Any documents, reports, or other products, with the exception of any and all proprietary business papers and documents, developed in connection with the performance of the Contract, shall be in the public domain and shall not be copyrighted or marketed for profit by the Provider, Alliance, any individual, or other entity; provided, however, that medical records, business records, and any other records related to the provision of care to and billing of Members' Services shall not be in the public domain. Alliance shall publish the name of Provider or Provider group in its provider directory. Provider authorizes such publication and consents to the use of its name, demographics, including practice specialties, phone numbers and addresses, in the Alliance provider directory listings for distribution to Alliance Enrollees.

16. **E-VERIFY:** Provider shall comply with the requirements of Article 2 of Chapter 64 of the North Carolina General Statutes. Further, if Provider utilizes a subcontractor, Provider shall require the subcontractor to comply.

17. **INDEMNIFICATION:** Provider agrees to indemnify and hold Alliance harmless to the extent allowed by law from all liability, loss, damage, claim and expense of any kind, including costs of the defense which results from negligent or willful acts or omissions by the Provider or its agents or employees regarding the duties and obligations of the Provider under this Contract or otherwise, including the duty to maintain the legal standard of care applicable to the Provider. If this Contract is terminated, the obligations of the Provider regarding indemnification under this Contract shall survive the termination of this Contract regarding any liability for acts or omissions that occurred prior to the termination.

Provider hereby releases and agrees to indemnify and hold harmless Alliance and agrees that Alliance, and each officer, and employee of Alliance shall not be liable for, any liabilities, obligations, claims, damages, (including but not limited to any civil or criminal penalties, and the repayment of any funds which an audit might disclose are due to be repaid to the State or Federal government or to the agencies of either), litigation costs and expenses (including attorney's fees and expenses) imposed on, incurred by or asserted against the Alliance, or any officer, or employee thereof for any reason whatsoever arising out of the Provider's negligent or willful actions or omissions in connection with the performance of the Contract.

18. **PROVIDER'S RESPONSIBILITY FOR QUALITY ASSURANCE AND QUALITY IMPROVEMENT:** Provider shall comply with the APSM 30-1, Alliance's Quality Management Plan

and, as a result of that participation, provide necessary performance data and cooperate with and participate in Quality Improvement projects and activities including but not limited to participation in the administration of surveys.

Provider will create a current Quality Improvement Plan (QI). Implementation of this plan will be reviewed during the Provider's monitoring reviews. Revisions/ updates to the Provider's QI shall be submitted to Alliance at the time of the Provider's implementation of the revised plan. Based upon information provided to the Provider by Alliance, the Provider will develop interventions to address needed areas of improvement and ensure that interventions are implemented and monitored for their level of effectiveness

Upon request, Provider shall cooperate fully with any investigation of Provider conducted by any Alliance department and particularly by the Quality Management Department and Provider Network Operations. Such cooperation shall include prompt and full response to Alliance. Participating Provider reserves all of its legal, equitable and constitutional rights hereunder.

ARTICLE III: OBLIGATIONS OF ALLIANCE

1. **REIMBURSEMENT:**

- a. Alliance shall timely reimburse Provider for duly authorized Services provided to Members and billed, contingent upon receipt of timely payments from the Department, according to the terms and conditions outlined in Article IV of this Contract and the Provider Manual.
- b. Alliance shall advise the Provider of any change in funding patterns that would affect reimbursement to the Provider based on availability of the various types of funds.
- c. All payments for Services to Providers shall be subject to review and audit for their conformity with applicable state and federal laws, rules and regulations and requirements contained in this Contract and the Provider Manual.
- d. Alliance may use different reimbursement methodologies or reimburse at amounts for different specialties or for different practitioners in the same specialty; and will establish measures that are designed to maintain quality of services and control cost consistent with its responsibilities to Recipients.
- e. Alliance may establish rates specific to a Provider, as Alliance determines necessary and appropriate. Alliance may offer different rates to different providers offering the same services according to Alliance's established reimbursement plan with criteria, such as paying enhanced rates for evidence-based practices or for positive outcomes.
- f. Alliance shall deny claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any denied claims billed shall be returned to the Provider with an explanation for the denial.
- h. For State Owned and Operated Facilities, Alliance shall reimburse facilities that are State-owned and operated by the Division of State Operated Healthcare Facilities according to the rates established by the Department.

2. **DATA TO PROVIDER:** Alliance shall provide data to the Provider related to delivery of Services under this Contract such as:

- a. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria;
- b. Information on benefit exclusions, where applicable;

- c. Administrative and utilization management requirements;
- d. Credential verification programs;
- e. Quality assessment programs; and
- f. Provider sanction policies.

Notification of changes in these requirements shall also be provided by Alliance on the Alliance website, in advance of the effective date of any changes in order to allow Providers time to comply with such changes.

3. **REFERRALS TO PROVIDER:** Provider will be included on a list of Providers available on the Alliance website and offered to Members who call the Alliance Access and Information Center for referral. Alliance reserves the right to suspend referrals to Provider in its reasonable discretion and to refer Members to other Providers. No referrals or authorizations are guaranteed to take place under this Contract. Provider shall have a “no-reject policy” for referrals within capacity and parameters of their competencies. Provider agrees to accept all referrals meeting criteria for services they provide when there is available capacity.

4. **UTILIZATION MONITORING:** Alliance shall monitor and review service utilization data related to the Provider and the Alliance Provider Network to ensure that services are being provided in a manner consistent with Controlling Authority.

5. **QUALITY ASSURANCE AND QUALITY IMPROVEMENT:** Alliance shall establish a written program for Quality Assessment and Performance Improvement in accordance with 42 CFR § 438.240 that shall include Members, family members and providers through a Global Quality Assurance Committee. Provider shall participate in the compliance process and the Alliance Network continuous quality improvement process. Alliance shall also:

- a. Provide Provider with a copy of the current program and any subsequent changes within thirty (30) days of changes to the Global Quality Assurance Plan.
- b. Measure the performance of Provider and Member specific outcomes from service provisions based on the global CQI performance 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 Provider.
- c. Measure Provider performance through medical record audits and clinical outcomes agreed upon by both Parties.
- d. Monitor the quality and appropriateness of care furnished to Members.
- e. Provide performance feedback to Providers including clinical standards and Alliance expectations.
- f. Follow up with Provider concerning grievances reported to Alliance by Members.

6. **CARE MANAGEMENT AND COORDINATION OF CARE:**

- a. Alliance shall ensure coordination of care and shall ensure that Tailored Care Management is available to all BH I/DD Tailored Plan members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative Care Management services.
- b. Alliance shall offer three (3) approaches to delivering Tailored Plan Care Management and shall adhere to the Program Requirements for each as set forth in the following Attachments, which are incorporated into this Contract by reference:
 - i. Advanced Medical Home (AMH+) Practices, as set forth in Attachment E – Advanced Medical Home Program Requirements for Medicaid and NC Health Choice Members; and

- ii. Care Management Agency (CMA), as set forth in:
 - (a) Attachment F -- Pregnancy Management Program Requirements for Medicaid and NC Health Choice Members; and
 - (b) Attachment G -- Care Management for High-Risk Pregnancy Program Requirements for Medicaid and NC Health Choice Members; and
 - (c) Attachment H -- Care Management for At-Risk Children Program Requirements for Medicaid and NC Health Choice Member; and
 - iii. BH I/DD Tailored Plan-based Care Managers.
 - c. Alliance shall coordinate the discharge of Members with Provider to ensure that appropriate services have been arranged following discharge and to link Member with other providers or community assistance.
 - d. Alliance shall provide follow up activities to high risk Members discharged from twenty-four (24) hour care.
 - e. If a Member requires medically necessary services, Alliance shall arrange for Medicaid-reimbursable services for the Member.
7. **AUTHORIZATION OF SERVICES:**
- a. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Alliance may deny payment for Covered Services where a Provider fails to meet Alliance's requirements for prior authorization.
 - b. Alliance shall determine whether Medical Necessity exists for those Services requiring prior authorization.
 - c. Alliance shall comply with the grievance and appeal requirements set forth in 42 CFR Part 438 and N.C. Gen. Stat. Chapter 108D.

ARTICLE IV: BILLING AND REIMBURSEMENT

1. Except for Emergency Services, Provider must verify the Member's Medicaid coverage in accordance with the Provider Manual prior to providing Covered Services or submitting claims to Alliance. Provider shall offer to assist any Member(s) who the Provider reasonably believes meet Medicaid eligibility requirements in applying for Medicaid. Alliance provides Member eligibility information through Alliance's provider website and other means.

For Emergency Services, Providers shall verify Member eligibility no later than the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Alliance may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Alliance.

2. Provider shall comply with all terms of this Contract even though a third party agent may be involved in billing the claims to the Alliance. It is a 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.

3. Provider acknowledges that this Contract allows Provider to bill Alliance only for those Medicaid-reimbursable Covered Services specifically identified in Attachment A and the Provider's credentialing approval letter that are medically necessary and provided to eligible Members at approved sites.

4. Provider understands and acknowledges 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, Alliance 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, Alliance shall be responsible for claims for 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.

5. Alliance will pay the Provider the lesser of the Provider's current usual and customary charges or Alliance's established rate for Services. Provider understands and agrees that reimbursement rates paid under this Contract are established by Alliance. Alliance reserves the right to establish its own rates as permitted under its Contract with the Department. The reimbursement rate can be revised unilaterally by the Department at any time. Alliance shall communicate any changes to reimbursement rates via publication on the Alliance website and electronic newsletter at least thirty (30) days prior to such change. Should rates change during the Contract period, Provider may elect to accept the revised rate or terminate the Contract.

6. Alliance follows the Department's guidelines regarding modifiers and only reimburses modifiers reimbursed by North Carolina Medicaid. Alliance may apply current North Carolina Medicaid payment rules, policies and guidelines related to Provider's claims. In accordance with DHHS Policy, where applicable Alliance will comply with payment requirements to reimburse providers no less than one-hundred percent (100%) of any applicable rate floor, as set forth in Attachment C and the Provider Manual. However, when contracting with Indian Health Care Providers, Alliance will adhere to requirements set forth in Attachment D for Indian Health Care Providers.

Behavioral Healthcare Providers will be reimbursed in accordance with the Alliance fee schedule published at [Document Library - Alliance Health \(alliancehealthplan.org\)](https://alliancehealthplan.org/document-library).

Outpatient Specialized Therapies (Speech Therapy, Occupational Therapy, Physical Therapy, Respiratory Therapy) will be reimbursed in accordance with the rate schedule published at <https://medicaid.ncdhhs.gov/providers/fee-schedules>.

7. **SUBMISSION AND PAYMENT OF CLAIMS:**

The Provider shall submit all claims for processing and Alliance shall process and pay claims in accordance with the terms set forth in Attachments B and C, which are attached hereto and incorporated herein. Participating Providers shall not submit claim or encounter data for services covered by the Alliance Tailored Plan directly to the Department.

- a. If Alliance denies payment of a claim, Alliance shall provide Provider the ability to electronically access the specific denial reason.
- b. Status of a claim shall be available within five to seven (5-7) days of Alliance's receipt of the claim.
- c. Alliance is not limited to approving a claim in full or requesting additional information for the entire claim. Rather, as appropriate, Alliance may approve a claim in part, deny a claim in part, and/or request additional information for only a part of the claim.
- d. Alliance will not reimburse Provider for services provided by staff not meeting licensure, certification or accreditation requirements.
- e. Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in Alliance's web based billing process.
- f. Claims must be submitted electronically either through HIPAA Compliant Transaction Sets 820 – Premium Payment, 834 – Member Enrollment and Eligibility Maintenance, 835 –

Remittance Advice, 837P – Professional claims, 837I – Institutional claims, or Alliance’s secure web based billing system. Provider will notify Alliance if electronic submission is not possible for a particular claim, and the Parties will work cooperatively to facilitate manual submission of the claim if necessary.

g. Provider’s claims shall be compliant with the National Correct Coding Initiative effective on the date of service.

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

i. Provider may submit claims beyond one-hundred-eighty (180) days in instances where the Member has been retroactively enrolled in the NC Medicaid Program or in the BH I/DD Tailored Plan, or where the Member has primary insurance which has not yet paid or denied its claim. In such instances, Provider should bill Alliance within thirty (30) days of receipt of notice by the Provider of the Member’s eligibility, or within ninety (90) days of final action (including payment or denial) by the primary insurance or Medicare or the date of service or discharge (whichever is later).

j. If Provider delays submission of the claims due to the coordination of benefits, subrogation of benefits or the determination of eligibility for benefits for the Member, Provider should submit such claims within thirty (30) days of the date of the notice of determination of coverage or payment by the third party.

k. If a claim is denied, and the Provider wishes to resubmit the denied claim with additional information, Provider must resubmit the claim within ninety (90) days after Provider’s receipt of the denial. If the Provider needs more than ninety (90) days to resubmit a denied claim, Provider must request and receive an extension from Alliance before the expiration of the ninety (90) day deadline, such extension not to be unreasonably withheld.

l. All claims shall be adjudicated as outlined in the Alliance Provider Manual.

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

n. 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.

o. Alliance shall not reimburse Provider for “never events” as that term is defined by the Centers for Medicare and Medicaid Services (CMS).

p. Provider shall not require co-pays, deductibles, or other forms of cost sharing for Covered BH, I/DD and TBI Services delivered to Medicaid and NC Health Choice Members under the Contract or charge Members or bill Alliance for missed appointments. For other Covered Services, Provider shall adhere to the Medicaid Managed Care Cost Sharing amounts established by the Department and available on the Alliance website at _____.

q. Provider shall comply with the requirements of 42 C.F.R. §438.3(g) including, but not limited to, the identification of provider-preventable conditions as a condition of payment, and appropriate reporting to Alliance.

r. Provider shall have policies and procedures that recognize and accept Medicaid as the payer of last resort.

8. **THIRD PARTY REIMBURSEMENT:**

a. Provider shall comply with N.C.G.S. § 122C-146, which requires the Provider and Alliance to make every reasonable effort to collect payments from third party payers. Each time a Member receives services Provider shall determine if the Member has third party coverage that covers the service provided. Provider shall report any third party coverage to the appropriate county Department of Social Services (DSS) within five (5) days of obtaining the information from a source other than DSS. Provider shall report any change in county of residence to Alliance.

b. Provider is required to bill all applicable third party payers prior to billing Alliance.

i. Medicaid benefits payable through Alliance 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 beneficiaries.

ii. Alliance 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 Alliance.

iii. Alliance does not make a secondary payment if the Provider is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.

iv. If Provider or Member receives a reduced primary payment because of failure to file a proper claim with the primary payer, Alliance's 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. Provider must inform Alliance that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

c. Provider shall bill Alliance for third party co-pays and/or deductibles only as permitted by Controlling Authority.

d. **Insurance.** If the Member has third party insurance for the services requested, but Provider does not have paneled staff, Provider must refer the Member to an eligible Network Provider or contact Alliance's Access Call Center for assistance in locating an eligible Network Provider. Alliance will not reimburse Provider for Covered Services provided to a Member with third party coverage by Provider's non-paneled staff. The third party payor reimbursement or denial information must be indicated on the claim submitted to Alliance. Claims submitted without third party information will be denied.

e. **Medicare.** If the Member has Medicare coverage for the services requested, but Provider does not have paneled staff, Provider must refer the Member to an eligible Network Provider or contact Alliance's Access Call Center for assistance in locating an eligible Network Provider. Alliance will not reimburse Provider for covered services provided to a recipient with Medicare coverage by Provider's non-paneled staff. Medicare reimbursement or denial information must be indicated on the claim submitted to Alliance. Medicaid claims submitted without Medicare information will be denied.

9. **FINANCIAL RECORDS:** Provider shall maintain detailed records of the administrative costs and expenses incurred pursuant to this Contract, including provision of Services and all relevant information relating to individual Members for the purpose of audit and evaluation by DHB and other Federal or State personnel. Records shall be maintained by Provider in accordance with APSM 10-3 and/or DHHS Records Retention and Disposition Schedule for Grants. When records are subject to two or more sets of standards, records must be retained for the longest period identified. All records must be retained if there is a reason to believe that they may be subject to an audit, investigation, or litigation. All costs associated with this Contract and shared with other Provider activities, whether contracted by Alliance or otherwise, shall be auditable.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

*Signature Page Between:***Alliance Health****and****Provider**

IN WITNESS WHEREOF, each Party has caused this Contract to be executed in multiple copies, each of which shall be deemed an original, as the act of said Party. Each individual signing below on behalf of Participating Provider certifies that he or she has been granted the authority to bind Provider to the terms of this Contract and any Addendums or Attachments/Appendices thereto.

Provider

Sign: _____
 Print Name: _____
 Title: _____
 Date: _____
 Tax ID: _____

Alliance Health

Sign: _____
 Name: Rob Robinson
 Title: CEO or Designee
 Date: _____

REQUIRED ATTACHMENTS/APPENDICES: This Contract consists of this master document and the following Appendices and Attachments, all of which are incorporated herein by reference:

- Appendix A Consolidated Federal Certifications and Disclosures**
- Appendix B Performance Outcomes and Reporting Requirements**
- Appendix C Mixed Services Protocol**
- Appendix D Insurance Requirements**
- Appendix E Electronic Provider Portal Access/ User Addendum**
- Attachment A Contracted Site and Services Codes**
- Attachment A-1 (Health/Hospital Systems Providers ONLY) Health System Medicaid Contract Services (Electronically Published at <https://www.alliancehealthplan.org/providers/publications-forms-documents/>)**
- Attachment B NC Medicaid Required Contract Terms**
- Attachment C Providers Subject to Rate Floors and/or Other Payment Directives**
- Attachment D Addendum for Indian Health Care Providers**
- Attachment E Advanced Medical Home Program Requirements for Medicaid and NC Health Choice**
- Attachment F Pregnancy Management Program Requirements for Medicaid and NC Health Choice**
- Attachment G Care Management for High-Risk Pregnancy Program Requirements for Medicaid and NC Health Choice**
- Attachment H Care Management for At-Risk Children Program Requirements for Medicaid and NC Health Choice**



APPENDIX A: CONSOLIDATED FEDERAL CERTIFICATIONS AND DISCLOSURES

The undersigned states that:

- (a) He or she is the duly authorized representative of the Provider named below;
- (b) He or she is authorized to make, and does hereby make, the following certifications on behalf of the Provider, as set out herein:
 - The Certification Regarding Nondiscrimination;
 - The Certification Regarding Drug-Free Workplace Requirements;
 - The Certification Regarding Environmental Tobacco Smoke;
 - The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
 - The Certification Regarding Lobbying;
- (c) He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the Contracted Services will be performed;
- (d) [Check the applicable statement]
 - ☒ He or she **has completed a Disclosure of Lobbying Activities** because the Provider **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;

OR

- ☐ He or she **has not completed a Disclosure of Lobbying Activities** because the Provider **has not made, and has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.

- (e) The Provider shall require its subcontractors, if any, to make the same certifications and disclosure.

Signature

Title

Enter Provider Name

Date

[This Certification Must Be Signed by the Same Individual Who Signed the Contract Execution Page]

I. Certification Regarding Nondiscrimination

The Provider certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. The Provider certifies that it will provide a drug-free workplace by:
 - a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Provider's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - b. Establishing a drug-free awareness program to inform employees about:
 - i. The dangers of drug abuse in the workplace;
 - ii. The Provider's policy of maintaining a drug-free workplace;
 - iii. Any available drug counseling, rehabilitation, and employee assistance programs; and

- iv. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
 - d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - i. Abide by the terms of the statement; and
 - ii. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
 - e. Notifying the Department within ten days after receiving notice under subparagraph (d)(ii) from an employee or otherwise receiving actual notice of such conviction;
 - f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(ii), with respect to any employee who is so convicted:
 - i. Taking appropriate personnel action against such an employee, up to and including termination; or
 - ii. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
 - g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).
2. The sites for the performance of work done in connection with the specific agreement are listed in Attachment A.
3. Provider will inform the LME/MCO of any additional sites for performance of work under this Contract per the terms of the Contract.
4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. see 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

Provider certifies that it will comply with the requirements of the Act. The Provider further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions Instructions

[The phrase "prospective lower tier participant" means the Provider.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549 and 45 CFR Part 75. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies**, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

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

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of \$100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

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APPENDIX B: PERFORMANCE OUTCOMES AND REPORTING REQUIREMENTS

SAMPLE



APPENDIX C: MIXED SERVICES PROTOCOL

(Applicable ONLY to Services received by Members enrolled in Medicaid Direct)

*Eligible ICD-10 Codes referenced in this Appendix C are found on the Alliance website:

Services	Claim Processing And/OR Financial
Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRGs)	LME/MCO in acute hospital or psychiatric unit of a hospital when DRG is psychiatric
Outpatient X-ray and Lab Work	DHB fee-for-service Medicaid <i>except</i> when provided during emergency room visits where the Revenue Code is one of the following (450-459, 900-919), and the primary ICD-10 code is an Eligible ICD-
Prescribed by LME/MCO network provider on an Inpatient basis such as VDRL, SMA, CBC, UA (urinalysis), cortisol, x-rays for admission physicals, therapeutic drug levels	DHB fee-for-service Medicaid fee-for-service Medicaid except when provided during emergency room visits where the Revenue Code is one of the following (450-459, 900-919), and the primary ICD-10 code is an Eligible ICD-10 Code*
Prescribed by LME/MCO network provider on an outpatient basis such as therapeutic drug levels	DHB fee-for-service Medicaid except for emergency room visits where the Revenue Code is one of the following (450-459, 900-919), and the primary ICD-10 code is an Eligible ICD-10 Code*
Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared	DHB fee-for-service Medicaid except for emergency room visits where the primary ICD-10 code is an Eligible ICD-10 Code*
Other tests ordered by non- LME/MCO physician	DHB fee-for-service Medicaid except for emergency room visits where the primary ICD-10 diagnosis code is an Eligible ICD-10 Code*
Drugs	
Outpatient prescription drugs and take home drugs	DHB fee-for-service Medicaid
Ambulance	

Transport to the hospital when the primary diagnosis is behavioral care	DHB fee-for-service Medicaid
Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	DHB fee-for-service Medicaid
Transfers authorized by LME/MCO from non-network facility to a network facility	LME/MCO
Consults	
Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit	LME/MCO
Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	LME/MCO
Medical/Surgical on Mental Health/Substance Abuse Unit	DHB fee-for-service Medicaid
Emergency Room Charges — Professional Services	
Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	LME/MCO
Emergency room services where the primary diagnosis on the claim is in the following range: Revenue Codes 450-459, 900-919 and the primary ICD-10 code is an Eligible ICD-10 Code*	LME/MCO
Emergency room services where the primary diagnosis on the claim is NOT in the following range: 290-319	DHB fee-for-service Medicaid

Services	Claim Processing And/Or Financial Liability
Emergency Room Facility Charge	
Emergency room services where the primary diagnosis on the claim is in the following range: Revenue Codes 450-459, and the primary ICD-10 code is an Eligible ICD-10 Code*	LME/MCO
Emergency room services where the primary diagnosis on the claim is NOT in the following range: 290-319	DHB fee-for-service Medicaid
Medical/Neurological/Organic Issues	
Stabilization of self-induced trauma poisoning	DHB fee-for-service Medicaid except for emergency room visits where the primary ICD-10 diagnosis code is an Eligible ICD-10 Code*
Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders	DHB fee-for-service Medicaid except for emergency room visits where the primary ICD-10 diagnosis code is an Eligible ICD-10 Code*
Miscellaneous	
Pre-Authorized, Mental Health, Alcohol/Substance Abuse admission, History and Physical	LME/MCO
Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or LME/ MCO authorized physician	LME/ MCO
Alcohol Withdrawal Syndrome and Delirium Tremens	
Alcohol withdrawal syndrome, Ordinary Pharmacologic syndrome characterized by elevated vital signs, agitation, perspiration, Anxiety and tremor that is associated with the abrupt cessation of alcohol or other Addictive substances. Detoxification services authorized by MCO/LME/PIHP. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs except when services are provided in the emergency room and the primary diagnosis an Eligible ICD-10 Code*	LME/ MCO
Delirium tremens (DTs), which is a complication of chronic alcoholism associated with poor nutritional status. This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening.	DHB fee-for-service Medicaid except for emergency room visits where the primary diagnosis is an Eligible ICD-10 Code*



APPENDIX D: INSURANCE REQUIREMENTS

INSURANCE: The Provider shall purchase and maintain insurance as listed below from a company, which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Should any of the described policies be reduced or canceled before the expiration date thereof, notice will be delivered in accordance with the policy provisions. Any loss of insurance shall be the basis of a payback to Alliance for services billed during this period and may result in the termination of this Contract. All insurance requirements of this Contract must be fully met unless specifically waived in writing by Alliance. The Provider shall purchase and maintain the following minimum coverage:

- a. Professional Liability: Professional Liability Insurance protecting the Provider and any employee performing work under the Contract for an amount of not less than \$1,000,000.00 per occurrence/\$3,000,000.00 annual aggregate.
- b. Comprehensive General Liability: Bodily Injury and Property Damage Liability Insurance protecting the Provider and any employee performing work under the Contract from claims of Bodily Injury or Property Damage arising from operations under the Contract for an amount of not less than \$1,000,000.00 per occurrence/\$3,000,000.00 annual aggregate.
- c. Automobile Liability: If Provider transports Enrollees, Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for an amount not less than \$500,000.00 each person and \$500,000.00 each occurrence. Policies written on a combined single limit basis shall have a minimum limit of \$1,000,000.00.
- d. Workers' Compensation and Occupational Disease Insurance, Employer's Liability Insurance: Workers' Compensation and Occupational Disease Insurance as required by the statutes of the State of North Carolina. And Employer's Liability Insurance for an amount not less than Bodily Injury by Accident \$100,000.00 each Accident/ Bodily Injury by Disease \$100,000.00 each Employee/Bodily Injury by Disease \$500,000.00 Policy Limit.
- e. Tail Coverage: Liability insurance may be on either an occurrence basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) for a period of not less than three (3) years after the end of the contract term, or an agreement to continue liability coverage with a retroactive date on or before the beginning of the contract term, shall also be provided.
- f. Any Provider utilizing any model for self-directing Innovations services and/or Agency With Choice services for Innovations enrollees shall carry Workers Compensation Insurance in accordance with the requirements of the DHB and Alliance Tailored Plan Contract and Innovations Waiver §1915(c) rules.
- g. Provider shall:

- i. Submit new Certificate of Insurance (COI) no later than ten (10) business days after the expiration of any listed policy to ensure documentation of continual coverage without demand by Alliance;
- ii. Notify Alliance in writing at least thirty (30) calendar days' before any coverage is suspended, voided, canceled or reduced;
- iii. Provide evidence to Alliance of continual coverage at the levels stated above within two (2) business days if Provider changes insurance carriers during the Term of the Contract, including tail coverage as required for continual coverage; and
- iv. Notify the Alliance in writing within two (2) business days of knowledge or notice of a claim, suit, criminal or administrative proceeding against Provider and/or Practitioner relating to the quality of services provided under this Contract. Upon notification, Alliance, 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
- v. All insurance requirements of this Contract shall be fully met unless specifically waived in writing by both Alliance and Provider.

In accordance with NC law, Provider may self-insure provided that Provider's Self-Insurance program is currently licensed/approved by the Department of Insurance of the State of North Carolina and has been actuarially determined sufficient currently to pay the insurance limits required in the Contract. Evidence of such self-Insurance may be submitted to Alliance for review and approval in lieu of some or all of the insurance requirements above.

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APPENDIX E: ELECTRONIC PROVIDER PORTAL ACCESS/ USER ADDENDUM

This Electronic Provider Portal Access/ User Addendum (“Agreement”), is made and entered as of the Effective Date of the Network Participating Provider Agreement by and between Alliance Health, (hereinafter “Alliance”) and the Provider (hereinafter “Provider”) named in the Network Participating Provider Agreement.

WITNESSETH:

WHEREAS, this Agreement is ancillary to the Network Participating Provider Agreement (“Contract”) executed between the Parties, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this Agreement shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, Alliance engages in the electronic transmission of data through use of Secured Technology Platforms (“Platforms”) that include the Alliance Claims System (ACS) and Jiva platforms. Both ACS and Jiva maintain Provider Portals that allow access to a database of sensitive information, which is confidential by law, regulation, or policy, or which is proprietary in nature (collectively, the “Data”). These Provider Portals are accessed by login credentials including as unique User Identifications (“User ID”) and password;

WHEREAS, Provider desires to enter into an Agreement with Alliance to obtain access to Data within the Platforms utilized by Alliance, including ACS and Jiva Provider Portals for treatment, payment, or healthcare operations purposes that are related to Provider’s obligations under the Contract;

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Alliance and Provider (hereinafter individually referred to as a “Party” and collectively as “Parties”) agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:



ATTACHMENT A: CONTRACTED SITES AND SERVICES CODES

Enter Provider Name

SAMPLE



FOR HEALTH AND HOSPITAL SYSTEMS ONLY

Attachment A-1 Health System Medicaid Contract Services

SAMPLE



ATTACHMENT B: NC MEDICAID REQUIRED PROVIDER CONTRACT TERMS

In accordance with the Alliance's Managed Care Contract with NC DHHS and the Department's instructions, the following language is incorporated into the terms of this Medicaid Network Participating Provider Contract (Contract) verbatim:

a. Compliance with state and federal laws

The Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and Alliance's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The Provider 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 Alliance'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.

b. Hold Member Harmless

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

c. Liability

The Provider understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against Alliance, its employees, agents or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the Provider by Alliance or any judgment rendered against Alliance.

d. Non-discrimination
Equitable Treatment of Members

The Provider agrees to render Provider Services to members with the same degree of care and skills as customarily provided to the Provider's patients who are not members, according to generally accepted standards of medical practice. The Provider and Alliance agree that members and non-members should be treated equitably. The Provider agrees not to discriminate against members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.

e. Department authority related to the Medicaid program

The Provider 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.

f. Access to provider records

The Provider 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, papers, and video recordings that relate to the Contract and/or the Provider's performance of its responsibilities under this Contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

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

The Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the NC Department of Health and Human Services.

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

g. Provider ownership disclosure

The Provider 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.

The Provider agrees to notify, in writing, Alliance and the NC Department of Health and Human Services of any criminal conviction within twenty (20) days of the date of the conviction.

h. Pursuant to N.C.G.S 108D-65.(6)(g):

- i. G.S. 58-3-200(c), Coverage Determinations. If Health Plan or its authorized representative determines that services, supplies, or other items are covered under its Benefit Plan, including any determination under G.S. 58-50-61, Alliance shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the 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.
- ii. G.S. 58-3-225, Prompt claim payments under health benefit plans. The Provider shall submit all claims to Alliance for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the Provider 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.
 - a. For Medical claims (including BH):
 1. Alliance shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
 2. Alliances shall pay or deny a clean medical at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
 3. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
 - b. For Pharmacy Claims:
 1. Alliance shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.
 2. A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.
 - c. 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, Alliance shall deny the claim per § 58-3-225 (d).
 1. Alliance shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).
 - e. If Alliance fails to pay a clean claim in full pursuant to this provision, the Alliance shall pay the Provider 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.
 - f. Failure to pay a clean claim within thirty (30) days of receipt will result in Alliance paying the Provider liquidated damages equal to one (1) percent 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.

- g. Alliance shall pay the interest and liquidated damages from subsections iv. and v. as provided in that subsection and shall not require the Provider to request the interest or the liquidated damages.iii. G.S. 58-3-227, Health plans fee schedules. When Alliance offers a contract to a Provider, Alliance shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of Provider. Upon the request of a provider, Alliance shall also make available the full schedule of fees for services or procedures billed by that class of Provider or for each class of Provider in the case of a contract incorporating multiple classes of Providers. If a Provider requests fees for more than 30 services and procedures, Alliance may require the Provider to specify the additional requested services and procedures and may limit the Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the Provider.
- iv. 58-50-270. Definitions. Unless the context clearly requires otherwise, the following definitions apply to Part 7 of Chapter 58. (1) "Amendment" – Any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an amendment. (2) "Contract" – An agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis. (3) "Health benefit plan" – A policy, certificate, contract, or plan as defined in G.S. 58-3-167. (3a) "Health care provider" – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients. (4) "Insurer" – An entity as defined in G.S. 58-3-227(a)(4). (2009-352, s. 1; 2009-487, s. 2(a).)
- v. G.S. 58-50-275, Notice contact provision. Each party has designated its Notice Contact in Article I, Paragraph 13 of this Contract.
- vi. § 58-50-280. Contract amendments. Health Plan shall send any proposed contract Amendment to Provider's Notice Contact of pursuant to G.S. 58-50-275 and as designated in Article I., Paragraph 13 of this Contract. The proposed Amendment shall be dated, labeled "Amendment," signed by Alliance, and include an effective date for the proposed Amendment. Provider shall have sixty (60) days from the date of receipt of a proposed Amendment to object to the proposed Amendment. The proposed Amendment shall be effective upon Contracted Provider failing to object in writing within 60 days.
- If Provider timely objects to a proposed Amendment, then the proposed Amendment is not effective and Health Plan shall be entitled to terminate the Agreement upon sixty (60) days' written notice to Contracted Provider.
- Nothing in this Agreement prohibits Provider and Health Plan from negotiating contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative Notice Contacts.
- vii. Health Plan shall provide a copy of its applicable policies and procedures to Provider prior to execution of a new or amended Contract and annually thereafter. Such policies and procedures may be provided in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Health Plan website. The policies and procedures of Health Plan shall not conflict with or override any term of a Contract, including Contract fee schedules. In the

event of a conflict between a policy or procedure and the language in a Contract, the Contract language shall prevail.

SAMPLE



ATTACHMENT C: PROVIDERS SUBJECT TO RATE FLOORS AND/OR OTHER PAYMENT DIRECTIVES

In accordance with DHHS Policy, where applicable Alliance will comply with payment requirements to reimburse providers no less than one-hundred percent (100%) of any applicable rate floor, as set forth in in this Attachment.

1. Physician and Physician Extender Payments

(a) The BH I/DD Tailored Plan shall reimburse all in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or bundle, as set by the Department, unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.

(b) The BH I/DD Tailored Plan shall reimburse all in-network physicians and physician extenders providing obstetric services no less than one hundred percent (100%) of the Medicaid Fee for Service rate for obstetrics services, which includes an enhanced rate for all vaginal deliveries (equal to the Medicaid Fee for Service rate for caesarian deliveries) unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.

(1) This includes reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6.

(c) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department and as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)).

(d) The BH I/DD Tailored Plan shall not refuse to reimburse for a covered service provided by a physician assistant in accordance with N.C. Gen. Stat. § 58-50-26.

2. Hospital Payments (Excluding BH Claims)

(a) The BH I/DD Tailored Plan shall reimburse all in-network hospitals no less than the applicable Medicaid Fee for Service rate specified below for inpatient and outpatient services (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(A)) and utilize the applicable Medicaid Fee for Service payment methodology, unless the BH I/DD Tailored Plan and hospital have mutually agreed to an alternative reimbursement amount or methodology.

(b) The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid Fee for Service rate using the Medicaid Fee for Service case weights and outlier methodology.

(c) The applicable rate floor and methodology for outpatient hospital services, including emergency department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.

(d) The hospital rate floors shall apply for the following defined time periods, after which the BH I/DD Tailored Plan will have flexibility to negotiate reimbursement arrangements with the hospitals:

(1) The first four (4) contract years for critical access hospitals and hospitals in economically depressed counties defined as Tier 1 or Tier 2 counties as designated by the North Carolina Department of Commerce for 2019 (https://files.nc.gov/nccommerce/documents/files/2019-Tiers-memo_asPublished.pdf).

- (2) The first two (2) contract years for all other hospitals.
 - (e) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))
 - (f) The Department shall reimburse hospitals directly for any graduate medical education payments due under the State Plan (as allowed under 42 C.F.R. § 438.60).
 - (g) The Department shall reimburse hospitals directly for Disproportionate Share Hospital Payments.
- 3. **Hospital Payments for BH Claims**
 - (a) The BH I/DD Tailored Plan shall negotiate inpatient and outpatient hospital rates with hospitals for BH claims to be defined by the Department.
- 4. **Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments**
 - (a) The BH I/DD Tailored Plan shall reimburse FQHCs and RHCs for covered services at no less than the following rates:
 - (1) All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.
 - (2) All core services shall be based on each FQHC's or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T-1015 code.
 - (b) The BH I/DD Tailored Plan shall provide the necessary data to the Department to enable the Department's payment of federally mandated wrap payments to FQHCs and RHCs using a template to be provided by the Department on a schedule to be defined by the Department.
- 5. **Indian Health Care Provider (IHCP) Payments**
 - (a) In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the BH I/DD Tailored Plan shall reimburse IHCPs as follows:
 - (1) Those IHCPs that are not enrolled as an FQHC, regardless of whether they participate in the BH I/DD Tailored Plan's Network;
 - (2) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
 - (3) The Medicaid Fee for Service rate for services that do not have an applicable encounter rate.
 - (4) Those IHCPs that are enrolled as FQHCs, but do not participate in the BH I/DD Tailored Plan's network, an amount equal to the amount the BH I/DD Tailored Plan would pay a network FQHC that is not an IHCP.
 - (b) The BH I/DD Tailored Plan shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
- 6. **Local Health Department (LHD) Payments**
 - (a) The BH I/DD Tailored Plan shall reimburse in-network LHDs no lower than base rates specified in the North Carolina Medicaid LHD Fee Schedule. The BH I/DD Tailored Plan shall reimburse the LHDs in accordance with this schedule for EPSDT well child exams, low-risk family planning and obstetrical services or sexually transmitted disease (STD) exams provided by enhanced role nurses.
 - (b) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for At-Risk Children services an amount substantially similar to or no less than the amount paid in NC Medicaid Direct (Fee for Service) prior to the start of the BH I/DD Tailored Plan contract (\$4.56 PMPM for all enrolled children ages zero (0) to five (5)).
 - (c) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an

amount substantially similar to or no less than the amount paid in Medicaid Fee-for-Service prior to the start of the BH I/DD Tailored Plan contract (\$4.96 PMPM for all enrolled women, ages fourteen (14) to forty-four (44)).

(d) The BH I/DD Tailored Plan shall negotiate base reimbursement amounts to in-network LHDs that are no lower than rates paid to non-public providers for similar services.

(e) In addition to base reimbursements, the BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network LHDs as defined by the Department and as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B).

(f) The BH I/DD Tailored Plan shall reimburse in-network LHDs providing lab services, as defined by the Department's Laboratory Fee Schedule, at no less than 100% of the Medicare Fee Schedule (as allowed under 42 C.F.R. § 438.6(c)), unless the BH I/DD Tailored Plan and LHD have mutually agreed to an alternative reimbursement arrangement.

7. **Public Ambulance Provider Payments**

(a) The BH I/DD Tailored Plan shall negotiate base reimbursement amounts to in-network public ambulance providers no lower than rates paid to non-public providers for similar services.

(b) In addition to base reimbursements, the BH I/DD Tailored Plan shall make additional utilization-based payments to in-network public ambulance providers for Medicaid members only, (not NC Health Choice beneficiaries) as defined by the Department and as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)).

(c) The BH I/DD Tailored Plan shall pay the negotiated base reimbursement to in-network public ambulance providers, which will serve as payment in full for NC Health Choice.

8. **State Owned and Operated Facilities Payments**

(a) The BH I/DD Tailored Plan shall reimburse facilities that are state-owned and operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) according to the rates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).

(b) At such time that the BH I/DD Tailored Plan is required to cover services provided by Veterans Homes operated by the DMVA, the BH I/DD Tailored Plan shall reimburse Veterans Homes according to the rates established by the Department in collaboration with DMVA (as allowed under 42 C.F.R. § 438.6(c)).

10. **Nursing Facility Payments**

(a) For Contract Year 1, the BH I/DD Tailored Plan shall reimburse in-network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid Fee for Service rate in effect the first day of each quarter (e.g., January 1, April 1, July 1 and October 1), unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.

11. **Hospice Payments**

(a) The BH I/DD Tailored Plan shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:

(1) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY)).

(2) For hospice services provided to members residing in nursing facilities, the BH I/DD Tailored Plan shall reimburse the hospice provider:

i. Hospice rate, and

ii. Ninety-five percent (95%) of the Medicaid Fee-for-Service nursing home room and board rate in effect at the time of service.

12. **Pharmacy Payments**

(a) The BH I/DD Tailored Plan shall adhere to the Department's pharmacy claims payments requirements.

13. **Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care**

Management Agencies (CMAs) for Tailored Care Management

(a) For Tailored Care Management, the BH I/DD Tailored Plan shall pay AMH+ practices and CMAs each of the following components:

- (1) Tailored Care Management payment for each month in which the AMH+ practice or CMA performed Tailored Care Management for each member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. These fixed rates shall apply for both Medicaid and CHIP members. This Tailored Care Management payment shall not be placed at risk. Management payment for any month in which the member is assigned to the AMH+/CMA and engaged in care management.
- (2) Performance incentive payment, if earned by the AMH+ or CMA. The performance incentive payment shall be based on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual, once released.

14. **Payments of Medical Home Fees to Advanced Medical Homes**

(a) In addition to the payment for services provided, the BH I/DD Tailored Plan shall pay all AMH practices a Medical Home Fee. "AMH practices" means all practices participating in the AMH program for the purposes of contracting with Standard Plans and BH I/DD Tailored Plans, including, but not limited to, AMH practices also certified as AMH+ practices for the purposes of Tailored Care Management.

(b) The BH I/DD Tailored Plan shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH Tiers 1 –3 practices may be prorated for partial months and shall be no less than the following amounts for Contract Years 1 and 2:

- i. \$1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the Medicaid Fee for Service program) (Tier 1 shall continue to exist only for the first year of BH I/DD Tailored Plan, or until the end of contract year two (2) of Standard Plans, whichever is sooner);
- ii. \$5.00 PMPM for all BH I/DD Tailored Plan members in Tier 2 and 3 practices (consistent with Age, Blind, and Disabled (ABD) beneficiaries under Carolina ACCESS II in the Medicaid Fee for Service program, and increasing the level of PMPM to \$5.00 for every BH I/DD Tailored Plan member, regardless of ABD status).

15. **Mutually agreed alternative reimbursement arrangement.** If the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate here:



ATTACHMENT D: ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS

The Contractor shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. *Purpose of Addendum; Supersession.*

The purpose of this Contractor Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between _____ (herein "Contractor") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Contractor's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.¹

2. *Definitions.*

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

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

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

- b. "Indian Health Care Provider (IHCP)" means a health care program operated by the

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

Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).).

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

3. *Description of IHCP.*

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

- ☐ IHS.
- ☐ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.
- ☐ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.
- ☐ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).
- ☐ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. *Cost Sharing Exemption for Indians; No Reduction in Payments.*

The Contractor shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who

is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. *Member Option to Select the IHCP as Primary Health Care IHCP.*

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

6. *Agreement to Pay IHCP.*

The Contractor shall pay the IHCP for covered Medicaid Managed Care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209. Persons Eligible for Items and Services from IHCP.

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

7. *Applicability of Federal Laws not Generally Applicable to other Providers.*

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

8. *Non-Taxable Entity.*

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Contractor to collect or remit any federal, state, or local tax.

9. *Insurance and Indemnification.*

- a. Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the Contractor network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

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

10. *Licensure and Accreditation.*

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

11. *Dispute Resolution.*

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

12. *Governing Law.*

The Contractor's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Contractor's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

13. Medical Quality Assurance Requirements.

To the extent the Contractor imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCA, 25 U.S.C. § 1675.

14. Claims Format.

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

15. Payment of Claims.

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

16. Hours and Days of Service.

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

17. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Contractor.

18. Sovereign Immunity.

Nothing in the Contractor's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

19. Endorsement.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the Contractor.

APPROVALS

For the Contractor:

For the IHCP:

Date: _

Date: _

Signature: _

Signature: _

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS as an IHCP:

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

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

- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCIA, 25 U.S.C. § 1601 et seq.;
- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

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

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



ATTACHMENT E: ADVANCED MEDICAL HOME PROGRAM REQUIREMENTS FOR MEDICAID AND NC HEALTH CHOICE

The following provisions include NC Medicaid Program Requirements and are incorporated into the Contract for applicable Service Providers. The Department reserves the right to amend these Requirements based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment and Provider agrees to comply with these requirements as they appear herein and as revised by the Department.

Advanced Medical Home (AMH) practices will be defined by an NPI and a service location. AMH Providers agree to the following terms and conditions:

- i. Accept members and be listed as a Primary Care Provider (PCP) in the BH I/DD Tailored Plan's member-facing materials for the purpose of providing care to members and managing their healthcare needs.
- ii. Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.
- iii. Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- iv. Provide direct patient care a minimum of thirty (30) office hours per week.
- v. Provide preventive services, in accordance with **Table 1: Required Preventive Services**.
- vi. Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan's medical record documentation guidelines.
- vii. Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
- viii. Transfer the Member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.
- ix. Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan's network adequacy standards.
- x. Refer for a second opinion as requested by the Member, based on Department guidelines and BH I/DD Tailored Plan standards.
- xi. Review and use Member utilization and cost reports provided by the BH I/DD Tailored Plan for the purpose of AMH-level Utilization Management and advise the BH I/DD Tailored Plan of errors, omissions or discrepancies if they are discovered.
- xii. Review and use the monthly enrollment report provided by the BH I/DD Tailored Plan for the purpose of participating in BH I/DD Tailored Plan or practice-based population health or care management activities.
- xiii. Comply with the Department's AMH+ Practice and CMA Certification Policy for Medicaid and NC Health Choice as published and updated by the Department.

Table 1: Required Preventive Services

Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	0 to 121	3 to 17	7 to 120	11 to 18	11 to 121	18 to 121	21 to 121
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus, Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenza Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y

Table 1: Required Preventive Services, con't													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	0 to 121	3 to 17	7 to 120	11 to 18	11 to 121	18 to 121	21 to 121
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

ATTACHMENT F: Pregnancy Management Program Attachment for Medicaid and NC Health Choice

The following provisions include NC Medicaid Program Requirements and are incorporated into the Contract for Obstetricians and Providers who offer prenatal, perinatal and postpartum services and thus are part of the Pregnancy Management Program as defined by the Department. The Department reserves the right to amend these Requirements based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment and Provider agrees to comply with these requirements as they appear herein and as revised by the Department.

Provider agrees to the following terms and conditions:

1. Complete the standardized risk-screening tool at each initial visit.
2. Allow the BH I/DD Tailored Plan or the BH I/DD Tailored Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
3. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
4. Commit to decreasing the cesarean section rate among nulliparous women.
5. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
6. Complete a high-risk screening on each pregnant BH I/DD Tailored Plan member in the program and integrate the plan of care with Tailored Care Management and/or Care Management for High-Risk Pregnancy.
7. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty (20) percent).
8. Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.
9. Send, within one (1) Business Day of the Provider completing the screening, all screening information and applicable medical record information for Members in care management for high-risk pregnancies to the applicable BH I/DD Tailored Plans, AMH+ practices or CMAs (as applicable), and the LHDs that are contracted for the provision of providing care management services for high-risk pregnancy.
10. Comply with the Department's Pregnancy Management Program Policy for Medicaid and NC Health Choice as published and updated by the Department.

ATTACHMENT G: CARE MANAGEMENT FOR HIGH-RISK PREGNANCY PROGRAM ATTACHMENT FOR MEDICAID AND NC HEALTH CHOICE

The following provisions include NC Medicaid Program Requirements and are incorporated into the Contract for Local Health Departments (LHD) contracted with the BH I/DD Tailored Plan as Providers of Care Management for High Risk Pregnancy, which refers to care management services provided to a subset of high-risk pregnant women by LHDs. The Department reserves the right to amend these Requirements based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment and Provider agrees to comply with these requirements as they appear herein and as revised by the Department.

Provider agrees to the following terms and conditions:

- A. General Contracting Requirement
 - i. LHD shall accept referrals from the BH I/DD Tailored Plan for Care Management for High-Risk Pregnancy services.
- B. Care Management for High-Risk Pregnancy: Outreach
 - i. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.
 - ii. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in care management.
- C. Care Management for High-Risk Pregnancy: Population Identification and Engagement
 - i. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) Calendar Days of receipt of risk screening forms.
 - ii. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.
 - iii. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.
 - iv. LHD shall review available BH I/DD Tailored Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.
 - v. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.
- D. Care Management for High-Risk Pregnancy: Assessment and Risk Stratification
 - i. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support.

- ii. LHD shall utilize assessment findings, including those conducted by the BH I/DD Tailored Plan, to determine level of need for care management support.
 - iii. LHD shall document assessment findings in the care management documentation system.
 - iv. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.
 - v. LHD shall assign case status based on level of patient need.
- E. Care Management for High-Risk Pregnancy: Interventions
 - i. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and/or other interventions needed to achieve Care Plan goals.
 - ii. LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.
 - iii. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.
 - iv. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.
 - v. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the Member's BH I/DD Tailored Plan Network.
 - vi. LHD shall document all care management activity in the care management documentation system.
- F. Care Management for High-Risk Pregnancy: Integration with the BH I/DD Tailored Plan and Health Care Providers
 - i. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.
 - ii. LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.
 - iii. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice in the county or serving residents of the county.
 - iv. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.
 - v. LHD shall ensure awareness of BH I/DD Tailored Plan Members "in network" status with providers when organizing referrals.
 - vi. LHD shall ensure understanding of the BH I/DD Tailored Plan's prior authorization processes relevant to referrals.
- G. Care Management for High-Risk Pregnancy: Collaboration with BH I/DD Tailored Plan
 - i. LHD shall work with the BH I/DD Tailored Plan to ensure program goals are met.
 - ii. LHD shall review and monitor BH I/DD Tailored Plan reports created for the Pregnancy Management Program and Care Management for High-Risk Pregnancy services to identify individuals at greatest risk.
 - iii. LHD shall communicate with the BH I/DD Tailored Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.
 - iv. LHD shall participate in pregnancy care management and other relevant meetings hosted

by the BH I/DD Tailored Plan.

H. Care Management for High-Risk Pregnancy: Training

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

I. Care Management for High-Risk Pregnancy: Staffing

- i. LHD shall employ care managers meeting pregnancy care management competencies, defined as having at least one of the following qualifications:
 1. Registered nurses
 2. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
 3. Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a Bachelor's or Master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.
- ii. LHD shall ensure that Community Health workers for Care Management for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
- iii. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.
- iv. If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
- v. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
- vi. LHD shall ensure that pregnancy care managers demonstrate:
 1. Proficiency with the technologies required to perform care management functions
 2. Motivational interviewing skills and knowledge of adult teaching and learning principles
 3. Ability to effectively communicate with families and providers
 4. Critical thinking skills, clinical judgment and problem-solving abilities
- vii. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
 1. Provision of program updates to care managers
 2. Daily availability for case consultation and caseload oversight
 3. Regular meetings with direct service care management staff
 4. Utilization of reports to actively assess individual care manager performance
 5. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual
- viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following BH I/DD

Tailored Plan/Department guidance about communication with the BH I/DD Tailored Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

- J. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the BH I/DD Tailored Plan.
- K. LHD shall comply with the Department's Care Management Program for High Risk Pregnancy Policy for Medicaid and NC Health Choice as published and updated by the Department.

SAMPLE

ATTACHMENT H: CARE MANAGEMENT FOR AT-RISK CHILDREN PROGRAM ATTACHMENT FOR MEDICAID AND NC HEALTH CHOICE

The following provisions include NC Medicaid Program Requirements and are incorporated into the Contract for Providers of Care Management for At-Risk Children, which refers to care management services provided by LHDs to a subset of the Medicaid population ages zero (0) to five (5) identified as being “high risk. The Department reserves the right to amend these Requirements based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment and Provider agrees to comply with these requirements as they appear herein and as revised by the Department.

Provider agrees to the following terms and conditions:

- A. Care Management for At-Risk Children: General Requirements
 - i. LHD shall collaborate with out-of-county organizations providing Tailored Care Management—AMH+ practices, CMAs, and BH I/DD Tailored Plans—to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.
 - ii. LHD shall identify or develop, if necessary, a list of community resources available to meet the specific needs of the population.
 - iii. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.
- B. Care Management for At-Risk Children: Family Engagement
 - i. LHD shall involve families (or a legal guardian, when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
 - ii. LHD shall foster self-management skill building when working with families of children.
 - iii. LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.
- C. Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level
 - i. LHD shall review and monitor BH I/DD Tailored Plan reports created for Care Management for At-Risk Children, along with the information obtained from the family, to ensure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.
 - ii. LHD shall use the information gained from the assessment to determine the need for services and the level of service to be provided. BH I/DD Tailored Plan Request for Applications
- D. Care Management for At-Risk Children: Plan of Care
 - i. LHD shall provide information and/or education to meet families’ needs and encourage self-management using materials that meet literacy standards.
 - ii. LHD shall ensure children/families are well linked to the child’s PCP.
 - iii. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving Care Plan goals.
 - iv. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child and use any locally developed resource list (including NCCARE360) to ensure families are well linked to resources to meet the identified need.
 - v. LHD shall provide care management services based upon the patient’s level of need as

- determined through ongoing assessment.
- E. Care Management for At-Risk Children: Integration with BH I/DD Tailored Plans and Health Providers
 - i. LHD shall collaborate with the member's PCP to facilitate implementation of patient-centered plans and goals targeted to meet individual children's needs.
 - ii. LHD shall ensure that changes in the care management level of care or in the need for patient support and follow-up and other relevant updates (especially during periods of transition) are communicated to the PCP and to the BH I/DD Tailored Plan.
 - iii. LHD shall ensure awareness of BH I/DD Tailored Plan Members "in network" status with providers when organizing referrals.
 - iv. LHD shall ensure understanding of BH I/DD Tailored Plans' prior authorization processes relevant to referrals.
 - F. Care Management for At-Risk Children: Service Provision
 - i. LHD shall document all care management activities in the care management documentation system in a timely manner.
 - ii. LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and shall work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.
 - G. Care Management for At-Risk Children: Training
 - i. LHD shall participate in Department or BH I/DD Tailored Plan-sponsored webinars, trainings and continuing education opportunities as provided.
 - ii. LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high-risk children.
 - H. Care Management for At-Risk Children: Staffing
 - i. LHD shall hire care managers who meet Care Management for At-Risk Children care coordination competencies and have at least one of the following qualifications:
 - 1. Registered nurses
 - 2. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
 - a. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as social workers under the Office of State Personnel guidelines.
 - ii. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.
 - iii. LHD shall ensure that Care Management for At-Risk Children care managers demonstrate:
 - 1. Proficiency with the technologies required to perform care management functions—particularly as pertains to claims data review and the care management documentation system
 - 2. Ability to effectively communicate with families and providers
 - 3. thinking skills, clinical judgment and problem-solving abilities
 - 4. Motivational interviewing skills, knowledge of trauma-informed care, and knowledge of adult teaching and learning principles
 - iv. LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.
 - v. If the LHD has only a single Care Management for At-Risk Children care manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance

from the non-represented professional discipline.

vi. LHD shall maintain services during the event of an extended vacancy.

vii. In the event of an extended vacancy, LHD shall complete and submit a vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.

viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight.

ix. LHD shall ensure that community health workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children care manager.

x. LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

1. Provision of program updates to care managers
2. Daily availability for case consultation and caseload oversight
3. Regular meetings with direct service care management staff
4. Utilization of monthly and on-demand reports to actively assess individual care manager performance

xi. LHD shall ensure that supervisors who carry a caseload also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

I. LHD shall comply with the Department's Care Management Program for High Risk Pregnancy Policy for Medicaid and NC Health Choice as published and updated by the Department.