CONTRACT AMENDMENT

This Contract Amendment is made and entered into this **XX** day of **MONTH, 20XX** by and between **Alliance Health** (hereinafter referred to as "Alliance") and **PROVIDER NAME** (hereinafter referred to as "Provider")

WITNESSETH:

WHEREAS, Alliance Health and Contractor entered into a contract dated _____, for the provision of **Tailored Plan Medicaid - Funded Services**, (hereinafter the "Original Agreement"); and,

WHEREAS, Alliance Health and Contractor desire to amend the Original Agreement, while keeping in effect all terms and conditions of the Original Agreement not inconsistent with the terms and conditions set forth below.

NOW, THEREFORE, for and in consideration for the mutual covenants and agreements made herein, the parties agree to amend the Original Agreement as follows:

1. Addition of the following Attachments, attached hereto and incorporated herein:
   a. Attachment A – Medicaid Direct Contracted Sites and Services Codes; and
   b. Attachment B – Medicaid Direct Addendum to Medicaid Network Participating Provider Contract; and,
   d. Appendix B – Mixed Services Protocol.

2. By execution hereof, the person signing for Provider below certifies that he/she has read this Contract Amendment and that he/she is duly authorized to execute this contract on behalf of the Provider.

3. Except for the changes made herein, the Original Agreement shall remain in full force and effect to the extent not inconsistent with this Amendment. In the event that there is a conflict between the Original Agreement and this Amendment, this Amendment shall control.

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IN WITNESS WHEREOF, the parties have expressed their agreement to these terms by causing this Contract Amendment to be executed by their duly authorized office or agent. This Contract Amendment shall be effective as of the date first written above.

PROVIDER NAME	**Alliance Health**
Sign: _____	By: _____
Print Name: _____	Title: COS or Authorized Designee
Title: _____	
Date: _____	Date: _____

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

By: _____
Title: Alliance Health Finance Officer or Authorized Designee

Date: _____

ATTACHMENT A
CONTRACTED SITES AND SERVICES CODES

Enter Provider Name

ATTACHMENT B :
MEDICAID DIRECT REQUIRED PROVIDER CONTRACT TERMS

In accordance with the Alliance's State Contract with NC DHHS and the Department's instructions, the following language is incorporated into the terms of this Medicaid Direct Network Participating Provider Contract (Provider Contract) **verbatim**. In the event of a conflict between the terms set forth in this Attachment J and the Provider Contract, this Attachment shall control:

1. 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.

2. 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 Medicaid Direct Benefit Plan so long as the member is eligible for coverage.

3. 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.

4. 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.

5. 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.

6. 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.

7. Prompt Claim Payments.

i. 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.

ii. 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.

iii. Alliance shall pay or deny a clean claim the lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

iv. A pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the

requested additional information. If the requested additional information on claim is not submitted within ninety (90) days of the notice requesting the required additional information, Alliance shall deny the claim.

v. Alliance shall reprocess claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

vi. If Alliance fails to pay a clean claim in full pursuant to this provision, the Alliance shall pay the Provider interest and penalties. 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.

vii. Failure to pay a clean claim within thirty (30) days of receipt will result in Alliance paying the Provider penalties 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.

viii. Alliance shall pay the interest and penalties from subsections vi. and vii. as provided in that subsection and shall not require the Provider to request the interest or the liquidated damages.

8. Contract amendments.

PIHP shall send any proposed contract Amendment to Provider's Notice Contact 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 PIHP shall be entitled to terminate the Agreement upon sixty (60) days' written notice to Contracted Provider.

Nothing in this Contract prohibits Provider and PIHP from negotiating contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative Notice Contacts.

9. Policies and Procedures. The policies and procedures of PIHP 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. PIHP's policies and procedures applicable to Providers shall be incorporated into PIHP's Provider Manual or posted to the PIHP website.

10. 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.

APPENDIX B: MIXED SERVICES PROTOCOL

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

***Eligible ICD-10 Codes referenced in this Appendix B 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 *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-
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*