This contract is funded with:
_____ State funding
_____ Block Grant funding*
*Non-Profits only
_____ County Funding

NETWORK PARTICIPATING PROVIDER CONTRACT FOR PUBLICLY AND STATE-FUNDED SERVICES

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 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 Covered Services and health care items to Alliance's Tailored Plan Recipients.

Provider Legal Name	**Enter Provider Name**

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 of 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-3.

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.

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. **Advanced Medical Home (AMH)/Advanced Medical Home Plus (AMH+)**: AMH shall refer to primary care practices certified by the Department, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population, or can otherwise demonstrate strong competency to serve that population. AMH+ practices must be certified by the Department as AMH Tier 3 practices and pass a readiness review administered by the National Committee for Quality Assurance.

d. **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.

e. **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.

f. **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).

g. **Benefit Plan:** The specific plan of benefits for publicly and State-funded health care coverage that is provided, sponsored or administered by Alliance directly or through its contractors, and contains the terms and conditions of a Recipient's coverage for Services, including exclusions and limitations, and all other provisions applicable to the coverage of such Covered Services.

h. **Benefit Plan Recipients (Recipients)**: Means those individuals who reside within the Alliance BH I/DD Tailored Plan Region, meet certain eligibility requirements and diagnostic criteria of a plan of services known as a benefit plan, and who are receiving services funded by Alliance from Provider pursuant to this Contract.

i. Care Management Agency (CMA): Provider organization with experience delivering BH, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management to BH I/DD Tailored Plan Members assigned to

it, under the Tailored Care Management model as certified by the State. CMAs must be certified by the State and pass a readiness review administers by the National Committee for Quality Assurance.

j. 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 NC DHHS 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.

k. **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.

l. **Contract:** means this 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.

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

n. **Covered Services:** means Medically Necessary health care items and Services covered under Alliance's State-funded Benefit Plan.

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

p. **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.

q. **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).

r. **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 B and incorporated herein.

s. **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.

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

u. **Encounter Data**: means encounter information, data and reports for Covered Services provided to a Recipient that meets the requirements for Clean Claims.

v. **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.

w. **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.

x. **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 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 Publicly and State-funded health care services.

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

z. **Medical Record:** means a single complete record, maintained by the Provider in one location, which documents all of the treatment plans developed for, and Covered Services received by a Recipient.

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

bb. **NC Tracks:** means the multi-payer 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.

cc. **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.

dd. **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.

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

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

gg. **Program Requirements**: means the requirements of Governmental Authorities governing a Provider's participation in Alliance's provider network and rendering Covered Services to Recipients pursuant to a Benefit Plan, including where applicable the requirements of a contract between the Governmental Authority and Alliance.

hh. **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.

ii. **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. 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/

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

kk. **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.

ll. **Recipient:** means an individual who is actively receiving a State-funded Service or State-funded function.

mm. **Service**: means medically necessary Covered Service(s) set forth in Attachment B that Provider is eligible and qualified to provide to Alliance's Recipients 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 the 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. **Tailored Care Management**: The care management model for BH I/DD Tailored Plan Members. Entities providing Tailored Care Management must be certified by the Department.

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 Services to Alliance Recipients. 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 shall be subject to the following, including any subsequent revisions or amendments thereto, (hereinafter referred to as the "Controlling Authority"):

a. Applicable provisions of North Carolina General Statutes Chapters 108A, 108D and 122C.
b. 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*.

c. All federal and state Recipient'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).
d. State licensure and certification laws, rules and regulations applicable to Provider.
e. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. § 108A-54.2.
f. The Alliance Provider Manual.
g. 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 10-5 and all applicable revisions, amendments, and/or updates. Provider shall comply with reporting requirements for data that is submitted directly to DHHS data systems. Information regarding reporting requirements can be found on the DMH/DD/SAS website at http://www.ncdhhs.gov/divisions/mhddsas.
h. 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.
i. The Drug Free Workplace Act of 1988.
j. 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 edited 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.

Provider understands and accepts the obligation to remove provider Staff or subcontractors when directed by Alliance or the Secretary of DHHS to achieve compliance with State and federal Law, rule, policy or standards and State Contract requirements.

7. **ASSURANCE OF THE RIGHTS OF RECIPIENTS**: The Provider shall comply with the implementation of all policies and procedures, created by Alliance for the assurance of the rights of Recipients served by the Provider, including its Member and Recipient Rights and Responsibilities Policy and all Laws, rules and/or regulations including Recipient grievance, appeal, and fair hearing procedures and timeframes as specified in Article 3, Part 1 of the North Carolina General Statutes Chapter 122C and rules promulgated thereunder.

Alliance is committed to ensuring that Recipients understand and can freely exercise their complaints and appeals rights and resolve issues efficiently with minimal burden to the Recipient or their Authorized Representative. Provider shall educate the Recipient on their rights and provide reasonable assistance with understanding and navigating the complaints and appeals processes. Provider's compliance with Recipient appeal, grievance and fair hearing procedures shall include Provider's cooperation with Recipient 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 Recipients 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 RECIPIENTS**: Providers shall not discriminate in their treatment of Recipients based on Recipients' 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) Recipients who obtain covered services shall not be subject to treatment or bias that does not affirm the Recipient's identifying orientation.

Providers shall not bill Recipients 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 Recipient for Covered Services. This provision shall not prohibit Provider and Recipient from agreeing to continue non-covered services at the Recipient's own expense, as long as Provider has notified Recipient in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the Recipient elects to receive the service with that understanding.
Providers may freely communicate with Recipients about their treatment regardless of Benefit Plan coverage limitations. Alliance does not dictate or control clinical decisions respecting a Recipient'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 Recipient regarding the Recipient's medical condition or available treatment options.

9. **TERM**: The Term of this Contract shall begin on the XXX day of Month, Year (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 ninety (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, an order by a Governmental Authority, or Alliance's contract with a Governmental Authority. The Effective Date of any Provider added under this Contract shall be the later of the Effective Date of this Contract or the date by which the Provider's enrollment is effective within NC Tracks or successor NC Medicaid provider enrollment system(s). Alliance reserves the right to impose shorter time limits on the Term of this Contract should Provider fail to comply with provisions set forth herein. In no case shall the Term of this Contract exceed the Term of Alliance's BH IDD Tailored Plan Contract with the Department. Notwithstanding the above, the term of this Contract, including any renewal, may be limited to comply with Laws, an order of a court or tribunal of competent jurisdiction, or by 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 appeal of an administrative action or sanction imposed by Alliance 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 appeal 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; and
f. Violation of terms between the BH I/DD Tailored Plan and Provider.

13. **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.

14. **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 **Enter Notice Contact Name** **Enter Title** **Enter Mailing Address** **Enter City, State, Zip Code**	Alliance Health ATTN: CONTRACTS 5200 West Paramount Parkway, Suite 200 Morrisville, NC 27560

Email:	Contracts@AllianceHealthPlan.org

15. **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.

16. **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, Recipient health and safety, Provider not meeting Recipient 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.

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 Recipients 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 Recipient in jeopardy. Conduct of Provider's employee(s) or agent(s) that threatens to place the health or safety of any Recipient 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 Recipient 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 Recipients; 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. 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. Provider is found to be an Ineligible Person, has been debarred, suspended terminated or is otherwise lawfully prohibited from participation in any federal or state government procurement activity;
   iii. Failure to meet or maintain Alliance's credentialing or re-credentialing standards;
   iv. The final substantiation and determination by the Department of Medicaid fraud and/or abuse.
   v. Under any of the following circumstances:
      a) 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;
      b) 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;
      c) 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; or
      d) 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.

      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;
   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.

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.

17. **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 Recipients 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 subsection g, below. If Alliance provides or arranges for the delivery of health care services on a prepaid basis, payment for Recipient's inpatient care shall be continued until the Recipient is ready for discharge.

e. In the event of termination the Provider shall submit all claims or registrations of putative Recipients within sixty (60) days of the date of termination.

f. In the event of any audit or investigation described in Article II, Paragraph 10, 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 Recipient prior to being discharged and provide Alliance with a list of Recipients 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 Recipient 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 Recipients 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 Recipients 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 Recipients 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.

18. **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 Recipients 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 Recipients served pursuant to this Contract:

a. Alliance is to notify the applicable Department Division(s) based on funding source and licensure, i.e. NC Medicaid, DMH/DD/SAS and/or DHSR) 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.

19. **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 I/DD 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.

20. **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.

21. **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.

22. **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.

23. **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 subcontractors.

24. **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.

25. **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, 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.

26. **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 Recipient choice requirements as set forth herein and in the Provider Manual.

2. **SERVICES:**

a. **Delivery of Services**. Provider agrees to provide the Medically Necessary Covered Service(s) to Recipients set forth in Attachment B 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, including Federal and State laws, rules, and regulations, and DHHS implementation updates, bulletins, manuals, Clinical Coverage Policies, State Service Definitions, the Provider Manual and all subsequent revisions. Provider shall utilize evidence based practices where

such exist, and to the extent they are required by applicable service definitions. 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 Recipients to or maintain a minimum number of Recipients with a Provider. Provider is required to serve Recipients within sixty (60) calendar days from the date of execution of this Contract. If Provider has not accepted and delivered services to Recipients 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 Recipient are required to notify Alliance of the Outpatient Commitment order upon receipt or notice of Outpatient Commitment.

d. **First Responder for Crisis/Emergency**. A Provider delivering a Service with defined first responder responsibilities or who is designated as such in the Person Centered Plan (PCP) (which will include a comprehensive crisis plan) shall act as first responder for the Recipient if and when the Recipient and/or a member of their support system initiates contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts to implement the established crisis plan, shall be referred to the Alliance's crisis service. Provider shall notify the Recipient and his/her support system of the process for accessing crisis/emergency services twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the event that Provider is not available. Crisis services do not require prior authorization.

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

3. **PROVIDER ACCESSIBILITY**:

Interpreting and Translation Services. Provider must make Language interpretation available by telephone and/or in person enabling Recipients to communicate with Provider. TDD (telecommunication devices for the deaf) must also be made available for Recipients 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 Recipient. The Provider must ensure that 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.

a. **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 applicable Clinical Coverage Policy or State Service Definitions, and offer hours of operation to Alliance Recipients 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. **Provider Accessibility Standards Related to Appointment Availability Requirements.** The Provider shall meet service availability and wait time standards as published on the Alliance Provider Manual, established in compliance with 42 C.F.R. § 438.206 and with Department requirements for Network Adequacy Standards for Medicaid. Provider acknowledges that:

i. Alliance shall monitor Network Providers regularly to determine compliance with timely access requirements;
ii. Alliance shall take corrective action if Provider fails to comply with service availability and wait time standards;
iii. Provider's cooperation with Alliance's monitoring of compliance with service availability and wait time standards is a requirement of this Contract.

No Reject Policy. Provider shall have a "no-reject policy" for Recipients 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 Recipient(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 and that 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. 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 and provide a copy of the notice to Alliance.

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

c. Provider must be actively enrolled with the Department as a State-funded Services provider in NC Tracks and is subject to termination of this Contract if such enrollment is not maintained in an active status.

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.
   iii. 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 C, 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, Alliance Provider Manual, or Mental Health, Developmental Disabilities, and Substance Abuse Service Definitions or other applicable Controlling Authority.

h. Provider, upon written request by Alliance, shall provide written proof of Provider accreditation.

8. **EVENT REPORTING AND ABUSE/ NEGLECT/ EXPLOITATION**: Provider shall use best efforts to ensure that Recipient(s) are not abused, neglected or exploited while in its care.

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

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

c. Provider shall timely report and comply with applicable Recipient 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.

d. 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 Recipients 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 acknowledges that it is subject to audits, investigations, evaluations and post-payment reviews, 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 Recipients, Recipients' clinical records, and any other clinical or financial items or documents related to the claims submitted for the delivery of Services to Recipients 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 Alliance 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.

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 Recipients, Recipients' clinical records, and any other clinical or financial items or documents related to the claims submitted for the delivery of Services to Recipients that Alliance deems necessary to ensure compliance with the Contract.

b. **Medical Records**. Providers shall maintain a Medical Record for each Recipient served in accordance with the standards set forth in applicable Federal and State laws, rules, and regulations, and DHHS implementation updates, bulletins, manuals, Clinical Coverage Policies, and State Service Definitions, including but not limited to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) Records Management and Documentation Manual - APSM 45-2. The original Medical Record related to services provided under this Contract shall be accessible to Alliance for review for the purpose of monitoring services rendered, financial audits by third party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by the Alliance and by State and Federal law, rules, regulation and policy. Upon request, Provider shall provide data about individuals for research and study to Alliance as permitted or required by DHHS and applicable Federal law. Upon request, Provider shall provide Medical Records information about Recipients referred by the Alliance for Quality Assurance and Utilization Management purposes of the BH I/DD Tailored Plan. Provider shall also:
   i. Maintain confidentiality of Recipient 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 I/DD 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 Recipient served, either in original paper copy or an electronic/digital copy.

   Provider shall maintain all documentation and records supporting Recipient'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 Recipients 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 NC DHHS with the provider name, type of provider, source of the complaint, and approximate dollars involved. Provider understands that the North Carolina Office of State Auditor 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 Recipient(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. **STATE CERTIFICATIONS**: Provider shall execute and comply with all governmental requirements applicable to the Covered Services being provided under this Contract, but not limited to the required State Certifications set forth in Appendix A and incorporated herein by reference.

13. **RECIPIENT GRIEVANCES**:

a. The Provider shall address all clinical concerns of the Recipient as related to the clinical Services provided to the Recipient 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 Recipients 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 RECIPIENT 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

Recipient, if requested by Recipient, determined to be clinically appropriate by the Recipient'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 Recipient to an in-network MAT Provider.

d. Provider shall coordinate the discharge of Recipients with Alliance to ensure that appropriate post-discharge services are arranged and to link Recipient 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 Recipient, 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 Recipient. Provider shall work and cooperate with the Alliance on coordination of care for any continuing services.

e. Provider must notify Alliance of any Recipient discharged from a high acuity clinical setting.

f. Alliance understands the importance of Recipient -Provider matching and that problems or incompatibilities can arise in the therapeutic relationship. Nevertheless, Provider shall, with the consent of the Recipient, collaborate with Recipient, Recipient'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 Recipient 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 Recipients' 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**:

a. 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.

b. **Clinical Outcome Measures.** Provider shall complete DHHS–required outcomes assessments on clients in accordance with DHHS guidelines and any subsequent changes thereto, including, but not limited to:
   i. timely submission of NC-TOPPS information and outcomes on individuals requesting and/or receiving non-Medicaid services through federal, State and county funds, as specified in the most current version of the NC-TOPPS Guidelines, located at https://www.ncdhhs.gov/divisions/mhddsas/reports/nc-topps and any subsequent changes thereto;
   ii. collection of outcome data for special populations such as consumers transitioning from residential facilities as a result of the 2012 U.S. Department of Justice Settlement Agreement with the State of North Carolina in accordance with the guidelines and the age and disability appropriate outcome instruments defined by Alliance; and
   iii. participation in surveys of provider staff and consumers conducted by DHHS and Alliance in accordance with DHHS guidelines and any subsequent changes thereto.

19. **PRESERVATION OF DHHS PUBLIC FUNDS**. Provider of Services paid for with State and/or federal block grant funds shall demonstrate good faith efforts to seek alternative and/or supplemental sources of funding or payment so as to reduce dependency on government monies. Providers shall encourage uninsured State-funded Services recipients and potential recipients to apply for Medicaid to obtain comprehensive insurance coverage.

20. **BLOCK GRANT REQUIREMENTS**. This contract may be funded with Substance Abuse Prevention & Treatment Block Grant funds in whole or in part. If funded with Block Grant dollars, Provider shall abide by the requirements and reporting obligations related to the Substance Abuse and Treatment Block Grant (SAPTBG), Community Mental Health Services Block Grant (CMHSBG), Social Services Block Grant (SSBG) and accompanying state Maintenance of Effort (MOE) requirements; Projects to Assist in the Transition from Homelessness (PATH) formula grant; Strategic Prevention Framework – State Incentive Grant (SPF-SIG), Safe and Drug Free Schools and Communities Act (SDFSCA), and all other applicable federal grant program funding compliance requirements, if

applicable. Information on the Block Grant review process, audit tools and review guidelines can be found on these websites: Substance Abuse Prevention & Treatment Block Grant requirements, at http://www.ncdhhs.gov/mhddsas/providers/Audits/index.htm and https://www.ecfr.gov/current/title-45/part-96/subpart-l

Provider shall cooperate and participate with Alliance and the Department in the DMH/DD/SAS's Independent Peer Reviews in compliance with Federal Block Grant regulations. Provider shall cooperate and participate with the Alliance and the Department in clinical fidelity review monitoring and technical assistance processes for evidence-based practices.

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

a. CMHSBG funds shall not be used to provide inpatient services;
b. SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except that SAPTBG funds may be used with the exception as described in 45 CFR §96.135 (c), along with documentation of the receipt of prior written approval of the DMHDDSAS Director of Financial Operations and the Chief of Addictions and Management Operations;.
c. SAPTBG and MHBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services. The provision of cash or cash cards is strictly prohibited, as is the provision of gift cards, which are considered to be cash equivalents.
d. SAPTBG and MHBG Funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment;
e. SAPTBG and MHBG Funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement);
f. SAPTBG and MHBG Funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity;
g. SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;
h. SATBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, holding facilities, etc.);
i. SAPTBG and MHBG Funds are prohibited to be used towards the annual salary of any contractor or subcontractor, including LME/MCO, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule;
j. Agencies or organizations receiving federal funds are required to receive prior written approval from the Chief of the Addictions and Management Operations Section regarding the use of evidence-based program incentives, including the specification of the type(s) and equivalent dollar value(s) of any such nominal incentives offered, and the manner of utilization of any such approved incentives for clients, recipients, students, or other persons. “Nominal incentives” are restricted to those of no more than twenty-five dollars ($25.00) in value per recipient, per event. Programs are strictly prohibited from utilizing any incentive items that could potentially be converted to cash, or that could be used for the purchase of any age-restricted product, such as tobacco, alcohol, drugs, weapons, or lottery tickets or any sexually oriented materials.
k. Federal funds shall not be utilized for law enforcement activities;

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

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

n. PATH formula grant funds shall not be expended:
   i. to support emergency shelters or construction of housing facilities;
   ii. for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or
   iii. to make cash payments to intended recipients of mental health or substance abuse services, except as permitted by 45 CFR § 96.135(c).

22. **RECIPIENT ELIGIBILITY FOR STATE-FUNDED SERVICES**. Every Alliance Recipient is evaluated to determine their ability to pay for state-funded services.

The process for determining financial eligibility is the responsibility of the provider. Providers are responsible for identifying and reporting any third-party payers and reporting family income to Alliance. It is the Provider's responsibility to verify individual/family income. Alliance will help determine if an individual has Medicaid, Medicare or private insurance through the screening process and will assist with residency determinations through verification of information submitted. Alliance follows the eligibility guidelines as established by the Department:

a) For BH Services:

   i. Income at or below 300% of poverty and
   ii. Insurance Status/Other Finance resources:

      a. Uninsured or insured with third-party insurance (including Medicaid) that:

         1. Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; or

         2. Covers the State-funded SUD service but associated cost sharing is unaffordable.

b) I/DD and TBI Services
   i. No income limits
   ii. Insurance Status/Other Finance Resources:

      a. Uninsured or insured with third-party insurance (including Medicaid) that:

         1. Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage and

         2. Applies for Medicaid coverage.

NC Medicaid and NC Health Choice beneficiaries who are members of Standard Plans are ineligible to obtain State-funded Services. Notwithstanding the foregoing, Alliance may instruct the Provider to waive eligibility criteria in the case of supporting the State's coordinated response to a disaster or state of emergency.

23. **RESTRICTIONS ON THE EXPENDITURE OF COUNTY FUNDING.** This contract may be funded in whole or in part with County Funds from a county in the Alliance Region. If funded with County

dollars, Provider shall abide by the restrictions, requirements and reporting obligations related to the funding source, as set forth in Attachment C, attached hereto and incorporated herein.

24. **CRISIS SERVICES**. To ensure that effective linkages are established and maintained between NC START and Alliance Mobile Crisis providers, a formal, written affiliation agreement shall be established and maintained with the NC START team in the Alliance Region. The agreement must be developed collaboratively between the Provider and the regional NC START team and shall outline the roles and responsibilities of both Parties as to Mobile Crisis. A copy of the affiliation shall be provided to Alliance upon request.

ARTICLE III: OBLIGATIONS OF ALLIANCE

1. **REIMBURSEMENT**:

a. Alliance shall timely reimburse Provider for duly authorized Services provided to Recipients 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. Non-Medicaid federal funds can only be contracted to not-for-profit organizations, in accordance with current federal block grant requirements. State and non-Medicaid federal funds may only be used to reimburse services that conform to State-approved service definitions.
d. 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.
e. 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.
f. 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.
g. 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 Recipients 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 Recipients 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. **MONITORING**: Alliance is obligated and authorized, pursuant to its contracts with DHHS, to monitor Services delivered under this Contract. Provider shall cooperate with, on-site reviews and/or investigations to evaluate compliance with applicable Federal and State laws, rules, and regulations, and DHHS implementation updates, bulletins, manuals, Clinical Coverage Policies and State Service Definitions governing the provision of Services under this Contract. Provider shall be subject also to monitoring by the Secretary of DHHS to assure that State Laws and regulations are met. Provider is expected to meet any and all core performance indicators set by the State and by Alliance.

Alliance will utilize the following information to monitor Provider performance: routine and focused monitoring reports, utilization management data, service effectiveness outcomes, data and reports submitted by the provider pursuant to the this Contract, quality of care outcome measures and thresholds, incident, grievance, complaint and appeal records, and consumer satisfaction surveys. Alliance shall provide training and technical assistance Alliance deems necessary and practical to Providers regarding administrative, clinical procedures and practices, as well as requirements specific to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG or SABG) and Community Mental Health Services Block Grant (CMHSBG or MHBG).

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 that shall include Recipients, family members and providers through a Global Quality Assurance Committee. Provider shall participate in the compliance process and the Alliance Network Continuous Quality Improvement (CQI) 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 Recipient 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 Recipients.
e. Provide performance feedback to Providers including clinical standards and Alliance expectations.

f. Follow up with Provider concerning grievances reported to Alliance by Recipients.

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 Alliance Recipients regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative Care Management services.
b. Alliance shall coordinate the discharge of Recipients with Provider to ensure that appropriate services have been arranged following discharge and to link Recipient with other providers or community assistance.
c. Alliance shall provide follow up activities to high risk Recipients discharged from twenty-four (24) hour care.
d. Alliance shall arrange medically necessary services for Recipients.

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 applicable grievance and appeal requirements set forth in N.C. Gen. Stat. Chapter 108D.

ARTICLE IV: BILLING AND REIMBURSEMENT

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

For Emergency Services, Providers shall verify Recipient eligibility no later than the next business day after the Recipient is stabilized or the Provider learning the individual may be a Recipient, whichever is later. Recipients' 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.

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

4. 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.

5. 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 and in the absence of an alternative reimbursement agreement, 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: https://www.alliancehealthplan.org/resources/document-library/?category=&types=&languages=&query=rates&sort=relevance

6. **PURCHASE OF EQUIPMENT**. If this Contract includes payment for equipment purchased with non-UCR, such as start up or special purpose expenditures, title to the assets purchased under this Contract in whole or in part rests with Alliance so long as the Provider continues to provide the services which are named in this Contract. If such services are discontinued, disposition of the assets shall occur as approved by the Department and in accordance with North Carolina law.

7. **RECOVERY OF OVERPAYMENTS**. Unless specifically approved otherwise in writing by Alliance Provider shall pay back within thirty (30) days to Alliance the amount paid by Alliance to Provider for all identified overpayments, whether due to error, non-compliance, fraud, or provider abuse.

8. **FINANCIAL RECORDS AND AUDITS**. 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 Recipients for the purpose of audit and evaluation by DHHS 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. All payments for services to Provider shall be subject to review and audit for their conformity with applicable State and Federal laws, rules and regulations and this Contract. Provider shall adhere to Generally Accepted Accounting Principles. When required and requested, Provider shall make available to Alliance its accounting records relating to services provided to or on behalf of Alliance under this Contract for the purpose of audit by DHHS for Federal authorities or by Alliance. Provider, when required by law or in accordance with the annual Contract between DHHS and Alliance, shall have an annual audit by an independent certified public accountant (CPA). If required, a copy of the independent audit shall be forwarded to:

Office of the State Auditor
2 South Salisbury Street
20601 Mail Service Center

Raleigh, NC 27699-0601

9. **CONTRACT CLASSIFICATION**. This Contract is a purchase of service Contract for UCR ("Uniform Claims Reimbursement") funds and a financial assistance Contract for non-UCR funds.

10. **EFFECT OF PAYMENT UPON TERMINATION**. 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 covered services not provided as of the date of termination, Provider shall promptly repay all excess funds. If additional payments are due from Alliance, said payments shall be made only after receipt of final invoice and report.

11. **SUBMISSION AND PAYMENT OF CLAIMS**. Provider shall not submit claim or encounter data for services covered by the Alliance Tailored Plan directly to the Department. Provider shall submit all claims for processing and Alliance shall process and pay claims in accordance with the following terms and conditions.

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 Recipient has been retroactively enrolled in the NC Medicaid Program or in the BH I/DD Tailored Plan, or where the Recipient 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 Recipient'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 Recipient, 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 Recipient, 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 Services under the Contract or charge Recipients or bill Alliance for missed appointments.
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.

12. **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 Recipient receives services Provider shall determine if the Recipient 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 Recipient 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 Recipient has third party insurance for the services requested, but Provider does not have paneled staff, Provider must refer the Recipient 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 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 Recipient has Medicare coverage for the services requested, but Provider does not have paneled staff, Provider must refer the Recipient 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. Claims submitted without Medicare information will be denied.

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	**Alliance Health**
Sign: _____	Sign: _____
Print Name:_____	Name: Sara Wilson,
Title:_____	Title: COS or Designee
Date: _____	Date: _____

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

By: _____
Title: Alliance Health Finance Officer 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	**Combined State Certifications**
Appendix B	**Electronic Provider Portal Access/ User Addendum**
Appendix C	**Insurance Requirements**
Attachment A	**Core Performance Indicators for Providers of MH/DD/SA Services**
Attachment A-1	**Performance Outcome and Reporting Requirements**
Attachment B	**Contracted Site(s) and Service(s) Codes/Scope of Work**
Attachment C	**County Funding Requirements (if funded with County dollars)**
Attachment D	**State-funded Required Provider Contract Terms**

Appendix A
State Certifications
Certifications Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. For purposes of these Certifications, Contractor is the same as Provider. The text of each North Carolina General Statutes and of the Executive Order can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- G.S. 133-32: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32
- Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): https://digital.ncdcr.gov/Documents/Detail/perdue-bev.-executive-order-no.-024-regarding-gifts-to-state-employees/4726639
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 143-133.3: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html
- G.S. 143B-139.6C: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf

Certifications

(1) **Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009)**, the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.

(2) **Pursuant to G.S. 143-48.5 and G.S. 143-133.3**, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov

(3) **Pursuant to G.S. 143-59.1(b)**, the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:

(a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); **and**

(b) [check **one** of the following boxes]

☐ Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; **or**

☐ The Contractor or one of its affiliates **has** incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 **but** the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.

(4) **Pursuant to G.S. 143-59.2(b)**, the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.

(5) Further, the undersigned certifies to the best of Contractor's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal or State department or agency.

(6) **Pursuant to G.S. 143B-139.6C**, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C and that a violation of that statute shall void the Agreement.

(7) The undersigned hereby certifies further that:

(a) He or she is a duly authorized representative of the Contractor named below;

(b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and

(c) He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1and -59.2 shall be guilty of a Class I felony.

Provider
Agency Name: _____

Signature _____ Date _____

Printed
Name _____ Title _____

APPENDIX B
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.

W I T N E S S E T H:

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:

ARTICLE I: RIGHTS AND OBLIGATIONS OF ALLIANCE

1.2 Provision of Access. Subject to Provider's compliance with the obligations set forth in this Agreement, Alliance agrees to provide Provider with one or more User IDs for Provider and its authorized employees, agents, and subcontractors (collectively, "Agents") to access certain Data residing in the Platforms such as the ACS and Jiva system databases that

relates to the individuals receiving MH/DD/SA services from Provider pursuant to the Contract.

1.3 Access to Secured Technology Platforms. Alliance shall use its best efforts to facilitate Provider's access to Platforms, including the ACS and Jiva systems; however, Provider acknowledges and agrees that its access to the Platforms and the Data shall be limited by and subject to scheduled computer system downtime and unanticipated software and hardware maintenance issues.

1.4 No Warranty. ALLIANCE EXPRESSLY DISCLAIMS ANY WARRANTY, EXPRESS OR IMPLIED, CONCERNING THE OPERATION OF ACS AND JIVA AND THE ACCURACY AND COMPLETENESS OF THE DATA MAINTAINED IN THE ACS AND JIVA DATABASES, INCLUDING BUT NOT LIMITED TO ANY WARRANTIES OF TITLE, OR MERCHANTABILITY, OR FITNESS FOR ANY PARTICULAR PURPOSE.

1.4 Costs. Alliance shall not charge Provider or its Agents for access to the Platforms, including ACS or Jiva systems unless charges are imposed upon Alliance by AlphaCM, Wellsky Corporation or Jiva, ZeOmega or any other third party for such access. In such event, Alliance shall provide thirty (30) days' written notice of the intent to impose an access fee.

1.5 Expense Reimbursement. Alliance shall not be liable to Provider or any agent for any expenses paid or incurred by Provider or any agent in connection with the Provider's or Agents' access to the Platforms, including, the ACS and Jiva systems.

1.6 Periodic Review. Periodically a Platform report may be run by Alliance to identify User IDs that have not logged into the Provider Portals for ninety (90) days. User IDs identified as not having accessed the Platforms within the last ninety (90) days may be made inactive. Provider must contact Alliance to request that User IDs be reactivated.

ARTICLE II: RIGHTS AND OBLIGATIONS OF PROVIDER

2.1 Account Management.

a. Provider shall determine which of its Agents shall need a User ID for access to the Platforms, which access shall be only for purposes related to Provider's obligations under the Contract.
b. Provider shall successfully complete and ensure that all Agents have successfully completed training on the Provider Portals before Alliance will issue a User ID.
c. Provider shall ensure that each Agent: Understands and complies with the terms of this Agreement; protects his or her User ID and password from disclosure; and does not share the assigned User ID and password with any other person.
d. Provider shall request issuance of User IDs for its Agents by completing the Provider Portal Access and Deactivation Request form located on the Alliance website.

e. Provider shall notify the Alliance Helpdesk to terminate or disable an Agent's User ID within one business day from the occurrence of any termination of employment, contract, or subcontract between Provider and such Agent, or upon the extended leave of an Agent for more than ninety (90) days, or at least five (5) business days prior to cessation of all or any part of Provider's business operations.
f. Alliance will periodically generate a list of Provider's Agents with User IDs, and Provider will confirm with Alliance whether the User IDs are to remain active within five (5) business days of Providers' receipt of the list, in accordance with the instructions provided by Alliance. Provider shall maintain records of User IDs for a period of six (6) years from the date of termination of an Agent's User ID.
g. Provider shall ensure that it and its Agents shall access only minimally necessary information in the Provider Portals as needed for the fulfillment of Provider's obligations under the Contract as those obligations directly relate to individuals receiving services from Provider pursuant to the Contract.
h. Provider shall ensure that it and its Agents shall not corrupt any Data in the Provider Portals and shall not damage or sabotage any Data or the Platforms.
i. Provider shall identify a security contact within its organization for Alliance to contact regarding any User ID issued under this Agreement. The security contact must be able to validate which of Provider's Agents shall have a User ID. Provider shall notify Alliance of any changes to the security contact within one (1) business day of such change.

2.1 Title to Intellectual Property. Provider understands acknowledges, and agrees that title, rights, and interest in and to the ACS and Jiva software and Data and other intellectual property shall be vested in Alliance and/or in AlphaCM and Jiva or other third parties and shall not be vested in Provider or any Agent.

2.2 Suspension of Connectivity. Provider understands, acknowledges and agrees that in the event of any incidents that Alliance determines in good faith present an unacceptably high risk to the Alliance information systems infrastructure, including, but not limited to, any Alliance data and information, that Alliance shall notify, and shall have the right to immediately suspend Provider's electronic access to the Alliance network and data until Alliance determines that the risk has been acceptably mitigated. Provider further understands, acknowledges and agrees that in the event that access is suspended, Alliance will not be liable for any losses resulting from Provider's loss of electronics access to Alliance's network and data.

ARTICLE III: TERM AND TERMINATION

3.1 Effective Date and Term. This Agreement shall become effective upon complete execution of the Network Participating Provider Contract and this Agreement by all Parties and shall continue thereafter until termination or expiration of the Contract or until termination of this Agreement as set forth herein, whichever is earlier.

3.2 General. Termination or suspension of Provider Portal access 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 Article III shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

3.3 Voluntary Termination. A voluntary termination of the Contract shall automatically result in a simultaneous voluntary termination of this Agreement and its accompanying access. This Agreement may be voluntarily terminated at any time upon the mutual consent of both Parties.

3.4 Involuntary Termination; Suspension of Access. Alliance may immediately, without prior notice, suspend Provider's and all or some associated Agents' User IDs, or terminate the Contract and this Agreement, if Alliance determines, in its sole discretion, that:

a. Provider or any Agent has breached a material term of this Agreement, or of the Contract between Alliance and Provider;
b. Alliance is no longer utilizing the Provider Portals on the ACS or Jiva platforms;
c. Provider's Contract with Alliance is terminated or expired;
d. Provider or any Agent has shared its login with any person, even if such person is another Agent of Provider;
e. Provider or any Agent has abused or sabotaged the ACS and/or Jiva platform or corrupted any data within the ACS or Jiva database;
f. Provider fails to timely provide and/or satisfactorily perform any requirement under this Agreement, including, but not limited to, timely submission of User ID deactivation requests, or required reports, records, or documentation;
g. Provider or an Agent is not compliant with federal or state confidentiality laws, rules, or regulations;
h. Provider has dissolved or ceased operations; or
i. Provider has been convicted of any felony, or of any crime involving health care.

3.5 Opportunity to Cure Not Required. Upon a determination that Provider meets a condition specified in Section 3.4, Alliance may, but is not required to, offer Provider the opportunity to cure by providing Provider with written notice of the material breach, specifying the breach and requiring it to be remedied within, in the absence of greater or lesser specification of time, fifteen (15) calendar days from the date of the notice; and if the breach is not timely cured, Alliance may terminate the Contract and this Agreement effective upon written notice of termination. If Provider and or its Agent(s) breaches any provision of this Agreement, Alliance shall have the right to withhold any payments due to Provider under any contract or agreement with Alliance, including but not limited to the Contract, until such breach has been fully cured.

3.6 Effect of Termination or Expiration. Upon termination or expiration of the Contract or of this Agreement pursuant to this Article III, Alliance shall disable any User IDs provided to Provider. In the event that Alliance terminates the Contract or suspends or terminates this Agreement in whole or in part pursuant to Section 3.4, Alliance may: (1) deduct any and all expenses incurred by Alliance for damages caused by the Provider and/or Agent's

breach; and/or (2) pursue any of its remedies at law or in equity, or both, including damages, injunctive relief, and specific performance.

3.7 Incorporation of Recitals. The recitals set forth above are an integral part of this Agreement and shall have the same contractual significance as any other language herein.

SIGNATURE PAGE

IN WITNESS WHEREOF, each Party intends this ELECTRONIC PROVIDER PORTAL ACCESS/ USER ADDENDUM to be under seal and has caused it to be executed in multiple counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument, as the act of said Party. Each individual electronically signing below certifies that he or she has been granted the authority to bind said Party to the terms of this Contract and any attachments, appendices, schedules or exhibits thereto.

By: _____
Provider DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Alliance Health:

By: _____
Sara Wilson, Chief of Staff or Designee

Date: _____

Appendix C
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. 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. 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 $500,0000.00 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 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 the LME/MCO;

ii. Notify Alliance in writing at least thirty (30) calendar days before any coverage is suspended, voided, canceled or reduced;

iii. Provide evidence to the 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 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 North Carolina 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.

ATTACHMENT A
CORE PERFORMANCE INDICATORS FOR PROVIDERS OF MH/DD/SA SERVICES

(Providers are expected to meet any and all benchmarks set by the State.)

1. Providers shall be responsible for full participation in the DHHS Routine Provider Monitoring process as conducted by the LME/MCO.

2. NC DHHS monitors the quality, access, timeliness and care management operations of LME-MCOs utilizing standardized performance measures. The performance measures and benchmarks set forth in Attachment A-1 have been identified by DHHS, and are incorporated into this Contract. These performance measures are applicable to all provider agencies and Licensed Independent Professionals (LIP) service individuals with State funding. Provider shall submit reports that are timely, accurate, and complete. The submission of late, inaccurate, or otherwise incomplete reports shall constitute a failure to report, and Provider shall be subject to corrective actions or penalties and sanctions

3. 100% of Level 1 incidents shall be recognized, adequately responded to, and reported/documented internally by the Provider. Level 1 incident report shall be maintained by the provider, separate from clinical records, at the provider's site.

4. At least 85% of Level 2 incidents shall be recognized, adequately responded to, and entered into the Incident Response Improvement System (IRIS) within 72 hours of learning of the incident. If IRIS cannot be accessed within that timeframe, providers may email or fax QM02, the DHHS Incident and Death Report form. The provider is still responsible for entering the incident in IRIS as soon as the system is available. Failure to submit the incident via IRIS may result in a plan of correction. Aggregate Level 2 incident reports shall be submitted to the LME-MCO via email to QMHelp@AllianceHealthPlan.org quarterly no later than January 10, April 10, July 10 and October 10.

5. At least 85% of Level 3 incidents shall be recognized, adequately responded to, reported to the LME/MCO within 24 hours of learning of the incident, and entered into the Incident Response Improvement System (IRIS) within 72 hours of learning of the incident. The Provider shall convene an incident review committee within twenty-four (24) hours. Deaths that occur within seven (7) days of seclusion or restraint are reported immediately to the LME/MCO. Aggregate Level 3 incident reports shall be submitted to the LME-MCO via email to QMHelp@AllianceHealthPlan.org quarterly no later than January 10, April 10, July 10 and October 10.

6. Providers shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. 100% of all substantiated client rights violations shall be reported through the Incident reporting process to the Customer Services/Consumer Affairs Unit of the LME/MCO Quality Management Department, and show evidence of being acted upon.

7. 100% of quality of care issues, as noted through LME/MCO monitoring, shall promptly begin to be addressed through the development and initiation of a corrective action plan submitted for approval to the LME/MCO within the time limits specified.

8. A representative sample of consumers shall be given the opportunity to express their *perception of satisfaction* for services received through the implementation of an empirical process no less often than once a year. The Provider is required to participate in the Division of MH/DD/SAS's annual Consumer Satisfaction Survey.

9. The Provider shall meet no less than 85% of established time frames for initial face-to-face consumer contact (Emergent: within two (2) hours from the date and time of the LME/MCO's determination of the need for services; Urgent: within forty-eight (48) hours of the request for services; Routine: fourteen (14) calendar days of the request for services).

10. The Provider shall agree to provide services within the following wait times:
    - Scheduled appointments – sixty (60) minutes after the appointment meeting time.
    - Walk-Ins – within two (2) hours after consumers' arrival or schedule an appointment for another day.

11. The Provider shall adhere to access to care, engagement, follow up after discharge from inpatient or community crisis performance benchmarks set by the DMH/DD/SAS. Additional outcomes may be required per the contract's Scope of Work.

12. Providers shall demonstrate 100% compliance with Operations Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS) and federal Mental Health Block Grant and Substance Abuse Prevention & Treatment Block Grant, as applicable. As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers and families).

13. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of three (3) improvement projects acted upon per year. Projects and results will be reported upon the request of the LME/MCO.

SPECIFIC SERVICE DELIVERY PERFORMANCE INDICATORS

The following subject headings may be used to issue specific guidance to Providers of certain services:

I. Financial
II. Staffing
III. Best Practice/Model Fidelity
IV. Definitions
V. Outcomes/Goals
VI. Reporting
VII. Administration/Management/Infrastructure
VIII. Collaboration
IX. Training
X. Program Development
XI. Monitoring Regulatory Updates
XII. Provider Community Responsibility

XIII. Professional Development
XIV. Committee Participation

ATTACHMENT A-1
PERFORMANCE OUTCOMES AND REPORTING REQUIREMENTS

General Guidelines

Alliance is responsible for statistical reporting of these indicators to DHHS. Alliance will monitor each Provider's performance based on "active service delivery" as determined by authorization and/or claims beginning and end dates for an episode of care (including authorization gaps caused by provider's failure to obtain timely reauthorization), pass-through days of service, and paid claims data for the measurement period. The source of the data for each measure includes the Alliance claims payment system and NC-TRACKS, and includes services rendered with dates of service within the measurement period for which a claim has been received, adjudicated, approved for payment and/or paid with State funds as of the date the report is generated. Reports will be generated 4 months after the end of the measurement period to allow for billing lag and processing. All encounter and shadow claims, as well as, sub-capitated service arrangements will be included. Service data would not include denied claims. Alliance will monitor data on a monthly and quarterly basis. If at any point a provider's performance falls below the established benchmark for any of the measures the provider will be notified by Provider Network staff to discuss corrective action steps.

Performance Measures and Benchmarks

Measure	Benchmark
MH Follow-Up After Discharge: The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
SUD Follow-Up After Discharge: The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%

Performance Measure Specifications

LME/MCO shall communicate any changes to Performance Outcomes and Reporting Requirements via publication on the LME/MCO website and electronic newsletter at least thirty (30) days prior to such change. Alliance will measure Provider's performance according to the provision of services identified below:

Table A: Codes to Identify Follow-Up Visits for Both Measures (Alliance is pulling claims by the base procedure code only.)

Exclude if Place of Service (POS) =
21 - Inpatient Hospital 23 - Hospital ED 51 - Inpatient Psychiatric Facility

Procedure Code	Description
	Stand Alone visits with a behavioral health practitioner:
90791	Clinical Evaluation/Intake
90791GT	Clinical Evaluation/Intake - telemedicine
90792	Interactive Evaluation
90792GT	Interactive Evaluation - telemedicine
90832	Individual Therapy (20-30 min.)
90832GT	Individual Therapy (20-30 min.) - telemedicine
90833	Individual Therapy (20-30 min.)--MD
90833GT	Individual Therapy (20-30 min.)--MD - telemedicine
90834	Individual Therapy (45-50 min.)
90834GT	Individual Therapy (45-50 min.) - telemedicine
90836	Individual Therapy (45-50 min.)--MD
90836GT	Individual Therapy (45-50 min.)--MD - telemedicine
90837	Individual Therapy (60 min.)
90837GT	Individual Therapy (60 min.) - telemedicine
90838	add-on code for individual psychotherapy, (60 min) when performed with an E&M service.
90838GT	add-on code for individual psychotherapy, (60 min) when performed with an E&M service - telemedicine
90839	Psychotherapy for Crisis (60 min.)
90840	Psychotherapy for Crisis (add-on) for each additional 30 min (used with 90839).
90847	Family Therapy with patient
90849	Group Therapy (Multiple Family Group)
90853	Group Therapy (non-multiple family group)
96101	Psychological testing, per hour (psychologist/physician)
96116	Neurobehavioral status exam, per hour (psychologist/physician)
96118	Neuropsych testing, per hour (psychologist/physician)
99201	Office or outpatient, E&M, new patient, problem focused, 10 min
99201GT	Office or outpatient, E&M, new patient, problem focused, 10 min - telemedicine
99202	Office or outpatient, E&M, new patient, expanded problem, 20 min
99202GT	Office or outpatient, E&M, new patient, expanded problem, 20 min - telemedicine
99203	Office or outpatient, E&M, new patient, detailed exam, low complexity, 30 min
99203GT	Office or outpatient, E&M, new patient, detailed exam, low complexity, 30 min - telemedicine
99204	Office or outpatient, E&M, new patient, comprehensive exam, moderate complexity, 45 min
99204GT	Office or outpatient, E&M, new patient, comprehensive exam, moderate complexity, 45 min - telemedicine
99205	Office or outpatient, E&M, new patient, comprehensive exam, high complexity, 60 min
99205GT	Office or outpatient, E&M, new patient, comprehensive exam, high complexity, 60 min - telemedicine

Procedure Code	Description
99211	Office or outpatient, E&M, established patient, may not require physician or other qualified health care professional, minimal problem(s), 5 min
99211GT	Office or outpatient, E&M, established patient, may not require physician or other qualified health care professional, minimal problem(s), 5 min - telemedicine
99212	Office or outpatient, E&M, established patient, problem focused, 10 min
99212GT	Office or outpatient, E&M, established patient, problem focused, 10 min - telemedicine
99213	Office or outpatient, E&M, established patient, expanded problem, low complexity, 15 min
99213GT	Office or outpatient, E&M, established patient, expanded problem, low complexity, 15 min - telemedicine
99214	Office or outpatient, E&M, established patient, detailed exam, moderate complexity, 25 min
99214GT	Office or outpatient, E&M, established patient, detailed exam, moderate complexity, 25 min - telemedicine
99215	Office or outpatient, E&M, established patient, comprehensive exam, high complexity, 40 min
99215GT	Office or outpatient, E&M, established patient, comprehensive exam, high complexity, 40 min - telemedicine
99241	Office consult, new or established patient, problem focused, 15 min
99241GT	Office consult, new or established patient, problem focused, 15 min - telemedicine
99242	Office consult, new or established patient, expanded problem, 30 min
99242GT	Office consult, new or established patient, expanded problem, 30 min - telemedicine
99243	Office consult, new or established patient, detailed exam, low complexity, 40 min
99243GT	Office consult, new or established patient, detailed exam, low complexity, 40 min - telemedicine
99244	Office consult, new or established patient, comprehensive exam, moderate complexity, 60 min
99244GT	Office consult, new or established patient, comprehensive exam, moderate complexity, 60 min - telemedicine
99245	Office consult, new or established patient, comprehensive exam, high complexity, 80 min
99245GT	Office consult, new or established patient, comprehensive exam, high complexity, 80 min - telemedicine
99341	Home Visit E&M New Pat, 20 min
99342	Home Visit E&M New Pat, 30 min
99343	Home Visit E&M New Pat Mod-Hi Severity, 45 min
99344	Home Visit E&M New Pat, 60 min
99345	Home Visit E&M New Pat, 75 min
99347	Home Visit E&M Est Pat, 15 min
99348	Home Visit E&M Est Pat, 25 min
99349	Home Visit E&M Est Pat, 40 min
99350	Home Visit E&M Est Pat, 60 min
H0012HB	SA Non-Medical Community Residential Treatment
H0013	SA Medically Monitored Community Residential Treatment
H0015	SA Intensive Outpatient Program (SAIOP)
H0020	Opioid Treatment
H0035	Mental health partial hospitalization, treatment, less than 24 hours (H0035)
H0040	Assertive community treatment program, per diem (H0040)
H2012HA	Child/Adolescent Day Treatment
H2015HT	Community Support Team

Procedure Code	Description
H2017	Psychosocial rehabilitation services, per 15 minutes (H2017)
H2022	Intensive In-Home Services
H2033	Multi-Systemic Therapy
H2035	SA Comprehensive Outpatient Treatment Program (SACOT)
T1023	Diagnostic Assessment
T1023GT	Diagnostic Assessment - telemedicine
YA308	Peer Support H0038 Individual
YA309	Peer Support H0038HQ Group
YA323	Assertive Engagement
YA324	Crisis Evaluation & Observation
YA325	Recovery support
YA341	Assertive Engagement
YA343	Peer Support Hospital Discharge and Diversion – Individual
YA344	Peer Support Transition
YA346	Hospital Discharge Transition Service
YA352	Assertive Engagement - QP (Licensed & Unlicensed)
YA353	Assertive Engagement - AP & Paraprofessional
YA356	Assertive Engagement
YA365	Assertive engagement
YA368	Assertive engagement
YA369	Crisis Evaluation & Observation
YA375	Peer Support Hospital Discharge and Diversion – Group
YA386	Outpatient DBT (Group)
YA387	Outpatient DBT (Individual)
YP400	Critical Time Intervention (CTI)
YP780*	Group Living High Intensity

*Count YP780 as a follow-up service only for persons with a primary or secondary SUD diagnosis receiving this service in a facility licensed under 10A NCAC 27G .3400 as a residential treatment facility for individuals with SUD.

ATTACHMENT B
CONTRACTED SITES AND SERVICES/SCOPE OF WORK

Enter Provider Name

ATTACHMENT C
COUNTY FUNDING REQUIREMENTS (if applicable)
(Fill in applicable County name) COUNTY FUNDING REQUIREMENTS

All or a part of the services provided in this Agreement are funded with (Insert County Name) funding. The terms of this Attachment C are a condition precedent to Alliance's obligation to tender County funding to Provider for the services provided to Eligible (Insert County Name) Residents funded hereunder.

For the purpose of this Agreement, a person is considered an Eligible (Insert County Name) Resident if he or she resides in (Insert County Name) at the time of admission (even if the individual owns or rents a home in a different county or state) subject to the following qualifications:

a. An individual in a hospital, mental institution, nursing facility (SNF, ICF-MR), Adult Care Home (rest homes/domiciliary care facility/assisted living), State prison, County jail or other institution/facility is a resident of the county in which he or she lived immediately prior to entering the facility. Residence in an adult care home does not establish county residence, even when the individual was a private paying adult care home resident.
b. If an individual moves from another state directly into an institutional living arrangement, the individual is a resident of the county in which the facility is located. If the individual moves to more than one institution/facility, the county of residence is the county where the first institution/facility is located.
c. Temporary absence from (Insert County Name), with subsequent return or intent to return, does not change the residence, unless it is determined that the individual is no longer receiving mail or paying utilities in (Insert County Name).
d. A person with no fixed or permanent address (i.e. homeless) is a resident of the county where the individual states his or her intent to remain. If the individual is incapable of stating an intent to remain, he is a resident in the county in which he is found. Under no circumstances shall a person with no fixed or permanent address be found to be a resident of (Insert County Name) if the individual states an intent to return to another county.

Provider shall not request funding under this agreement for the cost of services for individuals who are eligible and approved for Medicaid as determined by any State or County Department of Social Services, unless Provider first requests and receives approval from Alliance.

For all services funded by with (Insert County Name) dollars under this Agreement, Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that County funding under this Agreement shall be used only if and when other sources of first and third party payment, including Medicaid or State funding, private insurance, and self-pay have been exhausted. Provider shall make reasonable efforts to verify all insurance and other third party benefit plan details during first contact. In the event that an individual has private insurance, Provider is required to bill that individual's private insurance for services and receive determination of benefits prior to submitting any remaining eligible charges for services to Alliance for payment out of (Insert County

Name) funding under this agreement. (Provider is not required to bill another payor source that does not cover the provided service.) Provider shall include on its monthly invoices to Alliance the aggregate amounts of funds collected from Medicaid, Medicare and private insurers.

The parties agree and acknowledge that there may be isolated instances where (Insert County Name) funding is applied to the cost of services for individuals who are not (Insert County Name) residents due to inaccurate information received from the provider or individual that is outside the control of Provider and Alliance, in spite of reasonable efforts by Provider and Alliance to verify residency status. In such isolated cases, submitting claims for payment from (Insert County Name) funding shall not be deemed a breach of the terms of this contract, provided that.

Provider shall provide a report to Alliance for each category of funded (Insert County Name) services provided and billed by Provider for a funded program during the previous reporting period as of September 30, December 31, March 31, and July 31, due by the 15th business day of the subsequent month. Reporting obligations under this section survive the termination of this Agreement.

Audit Rights. For all (Insert County Name) Services being funded hereunder, Alliance and/or (Insert County Name) or its authorized representative shall have the right to inspect, examine, and make copies of any and all books, accounts, invoices, records and other writings related to the funding of the (Insert County Name) Services pursuant to this Agreement.

Provider shall be required at all times to use diligent and reasonable efforts to accurately determine residency of individuals consistent with the business practices in place at the execution of this Agreement.

Upon request, Provider shall provide Alliance in a timely manner with any information required to be included in the quarterly report to (Insert County Name).

ATTACHMENT D
State-funded Required Provider Contract Terms

In accordance with the Alliance's BH I/DD Tailored Plan contract with NC DHHS, Section VII - Second Revised and Restated Attachment G, the following language is incorporated into the terms of this State-Funded Provider Contract.

a. **Termination and Notice**

Alliance is permitted to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by Alliance or the Division, or upon termination of Alliance's contract by the State. Alliance is also permitted to immediately suspend some or all activities under the Contract upon the finding of a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the Alliance or the Division. Provider is required to notify Alliance of Members with scheduled appointment upon termination of all or a part of this Contract.

b. **Liability Insurance**

Provider's must to maintain professional liability insurance coverage in an amount acceptable to Alliance, and at Provider's sole cost, and to notify Alliance of subsequent changes in status of professional liability insurance on a timely basis.

c. **Provider Payment**

The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to Provider. However, the Contract shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in Alliance's web-based billing process.

d. **Contract Terms Addressing North Carolina General Statutes Chapter 58**

Pursuant to Section 5(6)g of Session Law 2015-245, as amended by Section 6(b) of Session Law 2018-49 pertaining to Chapter 58 protections:

i. G. S. 58-3-200(c), Coverage Determinations. If Alliance 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. 58-3-227, 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.

iii. G.S. 58-50-270(1), (2), and (3a), 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).)

iv. G.S. 58-50-275 (a) and (b), Notice Contact. Notice contact provision. Each party has designated its Notice Contact in Article I, Paragraph 13 of this Contract.

v. G.S. 58-50-280 (a) through (d), Contract Amendments. Alliance 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 Alliance shall be entitled to terminate the Agreement upon sixty (60) days' written notice to Contracted Provider.

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

vi. Alliance 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 Alliance website. The policies and procedures of Alliance 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.

vii. G.S. 58-51-37 (d) and (e), Pharmacy of Choice. A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, may not waive, discount, rebate, or distort a copayment of any insurer, policy, or plan, or a beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38.

At least 60 days before the effective date of any health benefit plan providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, the entity

providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the State.

e. **Clinical Records Requests for Claims Processing**

Alliance shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must at a minimum allow Provider to submit claim attachments electronically at the time of claim submission through an online portal and standard ASC X12 HIPAA transaction (275 claim attachment format or attachment indication in an 837 with the automated ability to link the separately received attachment to the claim and process the claim).

f. **Amendment of Previous Authorizations for Outpatient Procedures**

Alliance shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a result of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

g. **Physician Advisor Use in Claims Dispute**

Alliance shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.

The following provisions are required *verbatim* by NC DHHS and are incorporated into this Contract in compliance with Alliance's Tailored Plan contract.

a. **Compliance with State and Federal Laws**

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 the 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 Federal or state law.

b. **Hold Member Harmless**

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

c. **Liability**

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, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to Provider by Alliance or any judgment rendered against Alliance.

d. **Non-Discrimination Equitable Treatment of Members**

Provider agrees to render Provider Services to members with the same degree of care and skills as customarily provided to Provider's patients who are not members, according to generally accepted standards of medical practice. Provider and Alliance agree that members and non-members should be treated equitably. 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**

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**

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, and papers that relate to the Contract and/or Provider's performance of its responsibilities under the 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 Business Associate, audit firm, or quality assurance Business Associate 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.

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' Business Associates or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

g. G.S. 58-3-225, Prompt Claim Payments. 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 and, in the case of health care provider facility claims, within one-hundred-eighty (180) Calendar Days after the date of the Member's discharge from the facility. Provider shall submit all pharmacy point of sale claims within three-hundred-sixty-five (365) Calendar Days after the date of the provision of care to the Member. However, 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.

i. 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. Alliance 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.

ii. 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.

iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, 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).

iv. 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.

v. 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.

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

h. **Contract Effective Date**

The effective date of any Provider added under this Agreement shall be the later of the effective date of this Agreement or the date by which the Provider's enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).

i. **Tobacco-free Policy**

Unless the provider is a residential provider facility described below, Provider shall develop and implement a tobacco-free policy covering any portion of the property on which Provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting Provider from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients Provider serves.

Contracts with facilities that are owned or controlled by Provider and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required:

Provider shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

(1) Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by Provider.

(2) For outdoor areas of campus, Provider shall:

i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and

ii. Prohibit staff/employees from using tobacco products anywhere on campus.