PROCUREMENT CONTRACT FOR PROVISION OF SERVICES BETWEEN
PARTNERS BEHAVIORAL HEALTH MANAGEMENT
LME/PIHP
AND
[Company]
A PROVIDER OF MH/DD/SA SERVICES

ARTICLE I:
GENERAL TERMS AND CONDITIONS

1. DEFINITIONS:

A. "Catchment area" of the Local Management Entity/Prepaid Inpatient Health Plan (LME/PIHP) means the geographic part of the State served by a specific area authority or county program or LME and/or the counties participating in the PIHP and enrolled under Medicaid Provider Number 3404945. Partners BHM catchment area includes Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry and Yadkin counties.

B. "Clean Claim" means as defined in 42 C.F.R. §447.45(b).

C. "Contract" means this Procurement Contract for the Provision of Services between LME/PIHP and CONTRACTOR, including any and all Appendices and Attachments.

D. "Contractor" means [Company] , the provider of services pursuant to this contract, including all staff and employees of Contractor.

E. "Department" means the North Carolina Department of Health and Human Service and includes the Divisions of Medical Assistance (DMA) and Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SA).

F. "Emergency services" means as defined in 42 CFR §422.113 and §438.114.

G. "Enrollee" means an individual with a Medicaid county of residence located within the LME/PIHP catchment area enrolled with LME/PIHP.

H. "Local Management Entity" (LME) means the political subdivision organized pursuant to N.C.G.S. §122C-115.1 and 112C-115.2, and which is responsible for authorizing, managing and reimbursing providers for all Medicaid and State-funded mental health, substance abuse, and developmental disability services pursuant to contracts with the Department for those Enrollees within the LME/PIHP's defined catchment area.

I. "Notice" means a written communication between the parties delivered by trackable mail, electronic means, facsimile or by hand.

J. "PIHP" means the capitated Prepaid Inpatient Health Plan as defined in 42 CFR § 438.2 and operated by Partners Behavioral Health Management in accordance with the North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SA) health plan waiver authorized by the Centers for Medicare and Medicaid Services (CMS) pursuant to section 1915(b) of the Act, the N.C. Home and Community Based Services Innovations waiver authorized by CMS pursuant to section 1915(c) of the Act, and Part 438 of Title 42 of the Code of Federal Regulations.

K. "Post stabilization services" or "Post stabilization care services" mean as defined in 42 CFR §422.113 and §438.114.

L. "Provider Operations Manual" means the manual that is posted on the Partners BHM website, which has specific guidelines, instructions and requirements relating to this contract.

2. **BASIC RELATIONSHIP:**

CONTRACTOR enters into this contract with LME/PIHP for the purpose of providing medically necessary Mental Health, Developmental Disability, and/or Substance Abuse ("MH/DD/SA") services to the LME/PIHP's Enrollee(s) and agrees to comply with Controlling Authority, the conditions set forth in this Contract and all Appendices or Attachments to this Contract. CONTRACTOR is an independent contractor of LME/PIHP. This Contract is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between the parties, their employees, partners, or agents but rather CONTRACTOR is an independent contractor of the LME/PIHP. 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.

3. ENTIRE AGREEMENT/ REVISIONS:

This Contract, consisting of the Procurement Contract for the Provision of Services, and any and all Appendices and Attachments, constitutes the entire Contract between the LME/PIHP and the CONTRACTOR for the provision of services to Enrollee(s). Except for changes to Controlling Authority published by CMS, the LME/ PIHP, the Department, its divisions and/or its fiscal agent as referenced in Article I, Paragraph 4, any alterations, amendments, or modifications in the provision of the Contract shall be in writing, signed by all parties, and attached hereto.

4. CONTROLLING AUTHORITY:

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

a. Title XIX of the Social Security Act and its implementing regulations, N.C.G.S. Chapter 108A, the North Carolina State Plan for Medical Assistance, the North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SA) health plan waiver authorized by the Centers for Medicare and Medicaid Services (CMS) pursuant to section 1915(b) of the Act, and the N.C. Home and Community Based Services Innovations waiver authorized by CMS pursuant to section 1915(c) of the Act; and
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.*; and
c. All federal and state Enrollee's rights and confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards, 45 CFR Part 164, alcohol and drug abuse patient records laws codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2, the Health Information Technology for Economics and Clinical Health Act (HITECH Act) adopted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and those State laws and regulations denominated in Appendix G; and
d. Regulations concerning access to care, utilization review, clinical studies, utilization management, care management, quality management, disclosure and credentialing activities as set forth in 42 CFR parts 438, 441, 455, and 456.
e. State licensure and certification laws, rules and regulations applicable to CONTRACTOR; and
f. Applicable provisions of Chapter 122C of the North Carolina General Statutes; and

g. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. §108A-54.2; and
h. The North Carolina Medicaid and Health Choice Provider Requirements, N.C. Gen. Stat. Ch. 108C.
i. The Americans With Disabilities Act, Titles VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Vocational Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and subsequent amendments and regulations developed pursuant thereto, to the effect that no person shall, on the grounds of sex, age, race, religious affiliation, handicap, or national origin, be subjected to discrimination in the provision of any services or in employment practices; and
j. The Drug Free Workplace Act of 1988; and
k. Any other applicable federal or state laws, rules or regulations, in effect at the time the service is rendered and concerning the provision or billing of Medicaid-reimbursable or State-funded MH/DD/SA services, as specified in Appendix G.

CONTRACTOR agrees to operate and provide services in accordance with Controlling Authority. CONTRACTOR shall be responsible for keeping abreast of changes to Controlling Authority and to provide education and training to its staff and employees as appropriate. CONTRACTOR shall develop and implement a compliance program in accordance with 42 U.S.C. §1396a(kk)(5).

5. TERM:

The term of this Contract shall begin July 1, 2015 and shall remain in effect through, May 28**,** 2018, unless terminated by either party prior to the expiration of the specified term in accordance with paragraph 13 of this Contract. The LME/PIHP reserves the right to impose shorter time limits on the term of this Contract should CONTRACTOR fail to comply with the terms of this Contract. CONTRACTOR understands that State and Federal statutory and regulatory requirements may be changed or updated during the term of this Contract. The LME/PIHP will provide notice to the CONTRACTOR thirty (30) days prior to any changes to LME/PIHP manuals or forms. Any changes to reimbursement shall be in writing to CONTRACTOR thirty (30) days prior to such change.

6. CHOICE OF LAW/FORUM:

This agreement shall be interpreted in accordance with the laws of the State of North Carolina. The venue for all legal actions upon this Contract shall be in the State Courts of Gaston County or the U.S. District Court for the Western District of North Carolina, Charlotte Division.

7. HEADINGS:

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

8. COUNTERPARTS:

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

9. NONWAIVER:

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 have been satisfied, the other party shall be entitled to invoke any remedy available under the Contract, despite any such forbearance or indulgence.

10. DISPUTE RESOLUTION AND APPEALS:

The CONTRACTOR may file a complaint and/or appeals as outlined in the LME/PIHP Provider Manual promulgated by LME/PIHP pursuant to N.C. Gen. Stat. §122C-151.3 and as provided by N.C.G.S. Chapter 108C.

11. SEVERABILITY:

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

12. NOTICE:

Any notice to be given under this Contract will be in writing, addressed to the Contract Administrators designated by each party and noted at the address listed below, or such other address as the party may designate by notice to the other party, and will be considered effective upon receipt when delivery is either by trackable mail, postage prepaid, or by electronic means, or by fax, or by hand delivery.

[Company] [Company Address] [Company Phone] [Company E-mail]	Partners Behavioral Health Management 901 S. New Hope Road Gastonia, NC 28054 1-877-864-1454 contracts@partnersbhm.org

13. TERMINATION:

The Contract may be terminated under the following circumstances:

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

b. Either party may terminate the Contract with cause upon thirty (30) days notice to the other party; cause shall be documented in writing detailing the grounds for the termination. Cause for termination of the Contract may include, but is not limited to:
   i. Either party has failed to meet certification and/or accreditation standards required by any Controlling Authority; and/or
   ii. Loss of required facility or professional licensure, accreditation or certification by either party operating under this Contract; and/or
   iii. Failure of either party to implement or provide functions or services as specified in the Contract. Failure to provide timely complete and accurate documentation of services as required by this Contract may lead to withholding of funds or termination of the Contract; and/or
   iv. The conduct of either party or either party's employees or agents or the standard of services provided threatens to place the health or safety of any Enrollee in jeopardy. Conduct of the

either party's employee(s) or agent(s) that threatens to place the health or safety of any Enrollee in jeopardy shall not constitute grounds for termination of the entire Contract provided the party takes appropriate action toward said employee(s) or agent(s). Either party maintains its right to terminate this Contract should the other party fail to take appropriate action toward employees or agents whose conduct threatens to place the health or safety of any Enrollee in jeopardy; and/or

v. The LME/ PIHP discovers that CONTRACTOR is engaged in fraudulent or abusive billing, documentation or clinical practices; and/or
vi. CONTRACTOR fails to cooperate with any investigation of the CONTRACTOR authorized by Controlling Authority and deemed necessary by the LME/PIHP in regard to LME/PIHP Enrollees; and/or
vii. LME/PIHP fails to make payments as established in Article IV, Billing and Reimbursement; and/or
viii. LME/PIHP fails to make authorization as established in Article III, 7; and/or
ix. CONTRACTOR fails to reimburse the LME/PIHP for final overpayments identified by the LME/PIHP or fails to comply with payment plans established by the LME/PIHP as outlined in Article IV, Billing and Reimbursement; and/or
x. Any other material breach of this Contract.

c. This Contract may be terminated at any time upon mutual consent of both parties with mutually agreed upon notice to Enrollees.
d. The Contract may be terminated after sixty (60) days notice of termination to either party by one of the contracting parties.
e. In the event that Federal and State laws should be amended or judicially interpreted so as to render the fulfillment of the Contract on the part of either party unfeasible or impossible, both the CONTRACTOR and the LME/PIHP 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.

14. <u>EFFECT OF TERMINATION:</u>

a. The obligations of both parties under this Contract shall continue following termination, only as to the terms and conditions outlined in Article II, Paragraphs 4, 5, and 9, Article III, Paragraphs 1, 2, 7 and 8 and Article IV.
b. 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.
c. In the event of termination the CONTRACTOR shall submit all claims or registrations of putative enrollees within sixty (60) days of the date of termination.
d. The parties shall settle their respective debts and claims within the timeframes established within Article II, Paragraph 5, Article III, Paragraphs 7 and 8, and Article IV.
e. In the event of any audit or investigation described in Paragraph 14.b. above, 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 CONTRACTOR shall promptly refund all excess funds paid within the above-referenced thirty (30) days.
f. Continuity of Care: CONTRACTOR shall comply with Controlling Authority and provide notice to the LME/ PIHP with respect to the closing of a facility.

15. NON-EXCLUSIVE ARRANGEMENT:

The LME/PIHP has the right to enter into a Contract with any other provider of MH/DD/SA services. The CONTRACTOR shall have the right to enter into other Contracts with any other LME/PIHP or third party payers to provide MH/DD/SA services. Both parties shall ensure that any subcontractors performing any of the obligations of this Contract shall meet all requirements of the Contract.

16. NO THIRD PARTY CONTRACT RIGHTS CONFERRED

Nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by any third party, against LME/PIHP, CONTRACTOR or the Department.

Furthermore, nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by LME/PIHP or CONTRACTOR against the Department.

ARTICLE II:
RIGHTS AND OBLIGATIONS OF THE CONTRACTOR

1. DISCLOSURE:

a. The CONTRACTOR shall make those disclosures to the LME/PIHP as are required to be made to DMA pursuant to 42 C.F.R. §455.104 and 106 and are required by the LME/PIHP accrediting body. LME/PIHP will share accrediting body requirements with CONTRACTOR upon request.
b. To the extent any of the above required disclosure information is captured in current or existing Medicare or NC Medicaid enrollment application documentation, the LME/PIHP shall accept electronic or paper copies of such documentation as meeting this requirement. Entities no longer enrolled in Medicaid or Medicare will be required to independently meet all disclosure requirements of this Paragraph, federal and state laws, rules and regulations, and the LME/PIHP accrediting body.

2. LICENSES, ACCREDITATIONS, CREDENTIALING AND QUALIFICATIONS:

a. The CONTRACTOR 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. Within ten (10) days after the CONTRACTOR receives notice of any sanction by any applicable licensing board, certification or registration agency, or accrediting body which affect the ability of CONTRACTOR to bill the LME/PIHP for services, the Contractor shall forward a copy of the notice to the LME/PIHP.
b. The CONTRACTOR shall not bill the LME/PIHP:
    i. For any services provided by CONTRACTOR during any period of revocation or suspension of required licensure or accreditation of the CONTRACTOR's facility;
    ii. For any services provided by a member of the CONTRACTOR's staff during any period of revocation or suspension of the staff member's required certification, licensure, or credentialing.
c. The CONTRACTOR certifies that at the time of execution of this Contract, that neither CONTRACTOR, nor any of its staff or employees, is excluded from participation in Federal Health Care Programs under section 1128 of the Social Security Act and/or 42 CFR Part 1001. Within five (5) business days of notification of exclusion of CONTRACTOR or any of its staff

or employees by the U.S. Office of Inspector General, CMS or any other State Medicaid program, CONTRACTOR shall notify the LME/PIHP of the exclusion and its plan for compliance.

d. CONTRACTOR, upon written request by the LME/PIHP, shall provide the LME/PIHP with proof of CONTRACTOR accreditation and copies of accreditation reports as part of the credentialing process.
e. The LME/PIHP will conduct an assessment of the CONTRACTOR's qualifications to remain in the LME/PIHP's network at a minimum of once every three (3) years.

3. <u>EVENT REPORTING AND ABUSE/ NEGLECT/ EXPLOITATION:</u>

a. CONTRACTOR shall use best efforts to ensure that Enrollee(s) are not abused, neglected or exploited while in its care.
b. The CONTRACTOR shall report all events or instances involving abuse, neglect or exploitation of Enrollees as required by Controlling Authority. The CONTRACTOR must insure those incidents of actual or alleged abuse, neglect, and/or exploitation, the facts of the incident, and the action, if any, taken by the Contractor are reported to the LME's Consumer Relations Director or designee within seventy-two (72) hours of the initial report of the incident.
c. The CONTRACTOR shall not use restrictive interventions except as specifically permitted by the individual Enrollee's treatment/habilitation plan or on an emergency basis.
d. The LME/PIHP shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the CONTRACTOR. The CONTRACTOR shall cooperate fully with all such investigative requests. The LME/PIHP will provide the CONTRACTOR a written summary of its findings within 30 days. During such an investigation, if any issues are cited as out of compliance with this Contract or federal or state laws, rules or regulations, the CONTRACTOR may be required to document and implement a plan of correction. CONTRACTOR may contest and appeal a determination that claims were paid in error as outlined in the LME/PIHP Provider Manual promulgated by LME/PIHP pursuant to N.C. Gen. Stat. §122C-151.3 and Chapters 108C and 150B of the North Carolina General Statutes.

4. <u>BILLING AUDITS, DOCUMENTATION AND RECORDS RETENTION</u>:

a. The CONTRACTOR shall participate in and use best efforts to comply with the LME/PIHP'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 Enrollees whose services are reimbursed by the LME/PIHP. The CONTRACTOR shall provide the LME/PIHP with all necessary clinical information for the LME/PIHP's utilization management process. CONTRACTOR shall provide specifically denominated clinical or encounter information required by the LME/PIHP to meet State and Federal monitoring requirements within fifteen (15) days of the request, except that LME/PIHP may grant additional time to respond for good cause shown and depending upon the size and scope of the request. Additionally, CONTRACTOR will provide any requested documentation directly to the Department upon notification by the LME/PIHP or the Department of required documents for review. CONTRACTOR may satisfy any request for information by either paper or electronic/digital means.
b. The CONTRACTOR shall be responsible for completion of all necessary and customary documentation required for the services provided under the Contract in accordance with all Controlling Authority.
c. Documentation must support the billing diagnosis, the number of units provided and billed, and the standards of the billing code; and

d. CONTRACTOR shall maintain all documentation and records supporting Enrollee's medical necessity for the services and shall provide it to the LME/PIHP within fifteen (15) days of requests for program integrity activities, including but not limited to audits, investigations or post-payment reviews, except that LME/PIHP may grant additional time to respond for good cause shown and depending upon the size and scope of the request.
e. The CONTRACTOR agrees and understands that the LME/PIHP may inspect financial records concerning claims paid on behalf of Enrollees, records of staff who delivered or supervised the delivery of paid services to Enrollees demonstrating compliance with Controlling Authority, Enrollees' clinical records, and any other clinical or financial items related to the claims paid on behalf of Enrollees deemed necessary to assure compliance with the Contract. CONTRACTOR is also subject to audits, investigations and post-payment reviews conducted by the United States Department of Health and Human Services, including the Department's Office of Inspector General, CMS and the Department, or their agents. Program integrity activities do not have to be arranged in advance with CONTRACTOR.
f. The CONTRACTOR shall maintain a medical record and adhere to the federal record retention schedule for each Enrollee served, either in original paper copy or an electronic/digital copy.
g. CONTRACTOR agrees to maintain necessary records and accounts related to the Contract, including personnel and financial records in accordance with Generally Accepted Accounting Procedures and Practices to assure a proper accounting of all funds.
h. CONTRACTOR shall maintain detailed records of administrative costs and all other expenses incurred pursuant to the Contract including the provision of services and all relevant information relating to individual Enrollees as required by Controlling Authority. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are finally resolved.
i. At a minimum of once every two (2) years the CONTRACTOR will participate in an audit of paid claims conducted by the LME/PIHP. LME/PIHP shall conduct an entrance interview at the outset of any such audit. Any paid claims determined to be out of compliance with Controlling Authority shall require a repayment to the LME/PIHP as required by Controlling Authority. Any underpayments to CONTRACTOR shall require payment by the LME/PIHP. Audits shall be arranged with the CONTRACTOR in advance, except when the LME/PIHP has received a credible allegation of fraud, the health, safety or welfare of Enrollee(s) is at risk, or the LME/PIHP is participating in a joint investigation with the Department, its Divisions, its contractor(s) or another federal or state agency. At the conclusion of any such audit, the LME/PIHP shall conduct an exit conference with CONTRACTOR to discuss any tentative negative findings. The CONTRACTOR will receive written documentation of findings within thirty (30) days following the audit. Based upon results of the audit the CONTRACTOR may be subject to additional auditing and/or may be required to submit a plan of correction and /or may be required to remit funds back to the LME/PIHP as required by Controlling Authority. LME/PIHP may use statistical sampling and extrapolate audit results in accordance with Controlling Authority.
j. The CONTRACTOR shall use best efforts to provide data to the LME/PIHP in the implementation of any studies or improvement projects required of the LME/PIHP by the Department. CONTRACTOR and LME/PIHP will mutually agree upon the data to be provided, and the format and time frame for provision of the data.
k. In accordance with Controlling Authority, specifically 42 CFR §420.300 through §420.304, for any contracts for services the cost or value of which is $10,000 or more over a 12-month period, including contract for both goods and services in which the service component is worth $10,000 or more over a 12-month period, the Comptroller general of the United States, HHS, and their duly authorized representative shall have access to CONTRACTOR's books, documents, and records until the expiration of four years after the services are furnished under the contract.

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

a. CONTRACTOR understands that whenever LME/PIHP receives a credible allegation of fraud, abuse, overutilization or questionable billing practice(s), the LME/PIHP is required to provide the Division of Medical Assistance with the provider name, type of provider, source of the complaint, and approximate dollars involved. CONTRACTOR understands that the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office or the Division of Medical Assistance, at their discretion, may conduct preliminary or full investigations to evaluate the suspected 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 CONTRACTOR never rendered or for which documentation is absent or inadequate.

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

c. If the LME/PIHP or CONTRACTOR determines that the CONTRACTOR has received payment from the LME/PIHP as a result of an error or omission, the LME/PIHP will provide thirty (30) days notice to the CONTRACTOR of its intent to recoup funds related to errors or omissions. The LME/PIHP will provide an invoice to the CONTRACTOR including the Enrollee(s) name and date(s) of service in question. CONTRACTOR shall have thirty (30) days from date of such notification to either appeal the determination of the LME/PIHP or to remit the invoiced amount.

d. Requests for Reconsideration by the CONTRACTOR and appeals of audit determinations are as defined by Controlling Authority and as outlined in the LME/PIHP Provider Manual promulgated by LME/PIHP pursuant to N.C. Gen. Stat. §122C-151.3 and Chapters 108C and 150B of the North Carolina General Statutes.

e. CONTRACTOR understands and agrees that self-audits are encouraged by the LME/PIHP.

6. **FEDERALLY REQUIRED CERTIFICATIONS:**

The CONTRACTOR shall execute and comply with the attached federally required certifications, as follows:

a. Environmental Tobacco Smoke – Certification for Contracts, Grants, Loans and Cooperative Agreements,

b. Lobbying – Certification for Contracts, Grants, Loans and Cooperative Agreements,

c. Drug-Free Workplace Requirements, and

d. Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions.

7. **ENROLLEE GRIEVANCES:**

a. The CONTRACTOR shall address all clinical concerns of the Enrollee as related to the clinical services provided to the Enrollee pursuant to this contract. CONTRACTOR shall refer any unresolved concerns or requests for LME/PIHP services or provider change to the LME/PIHP. The CONTRACTOR 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 Enrollees and that said process operates in a fair and impartial fashion.

b. The LME/PIHP may receive complaints directly, which involve the CONTRACTOR. If a complaint is received by the LME/PIHP, State rules/regulations regarding the investigation and/or mediation of complaints will be followed. Based on the nature of the complaint, the LME/PIHP may choose to investigate the complaint, as authorized by Controlling Authority, in order to determine its validity. CONTRACTOR will be required to cooperate fully with all investigative requests as required by Controlling Authority.
c. The LME/PIHP will maintain documentation on all follow up and findings of any complaint investigation. The CONTRACTOR will be provided a written summary of the LME/PIHP's findings.
d. During an investigation, if any issues are cited as out of compliance with this Contract or Controlling Authority, the CONTRACTOR may be required to document and implement a plan of correction as required by Controlling Authority. The CONTRACTOR will maintain a system to receive and respond timely to complaints received regarding the CONTRACTOR. The CONTRACTOR will maintain documentation on the complaint to include, at a minimum, date received, points of complaint, resolution/follow up provided, and date complaint resolved.

8. <u>ACCESS BY THE LME/PIHP TO ENROLLEES AND ENROLLEE CARE MONITORING:</u>

a. CONTRACTOR shall coordinate the discharge of Enrollees with LME/PIHP to ensure that appropriate services have been arranged following discharge and to link Enrollee with other providers or community assistance. CONTRACTOR shall also allow appropriately credentialed LME/PIHP staff direct access to any Enrollee, if requested by Enrollee, determined to be clinically appropriate by the Enrollee's treating physician, and requested in advance by the LME/PIHP. CONTRACTOR shall endeavor to provide at least twenty-four (24) hours prior notice to the LME/PIHP of the intended date and time of any discharge of an Enrollee
b. The LME/PIHP understands the importance of Enrollee-CONTRACTOR matching and that problems or incompatibilities arise in the therapeutic relationship. Nevertheless, CONTRACTOR shall with the consent of the Enrollee, collaborate with Enrollee, Enrollee's family members, and the LME/PIHP to assure continuity of care and that there is no disruption of service. The LME/PIHP will work collaboratively with the CONTRACTOR to resolve any problem(s) of continuity of care or in transferring the Enrollee to another provider.

9. <u>PROPRIETARY INFORMATION AND INTELLECTUAL PROPERTY</u>:

Neither the CONTRACTOR nor the LME/PIHP shall publish or disseminate any advertising or proprietary business material either printed or electronically transmitted (including photographs, films, and public announcements) or any business papers and documents which identify the other party or its facilities without the prior written consent of the other party. Any documents, reports, 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 CONTRACTOR/ the LME/PIHP, 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 patients shall not be in the public domain. The LME/PIHP acknowledges in advance that any documents or data concerning administrative costs and all other expenses submitted by CONTRACTOR pursuant to this Contract are restricted as confidential trade secrets pursuant to a request per N.C. Gen. Stat. §132-1.2.

10. <u>CONFIDENTIALITY</u>:

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

11. HOURS OF OPERATION:

The CONTRACTOR shall offer, at a minimum, hours of operation that are no less than the hours of operation offered to Medicaid Fee-For-Service recipients.

12. ADVOCACY FOR ENROLLEES:

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

ARTICLE III:
RIGHTS AND OBLIGATIONS OF THE LME/PIHP

1. REIMBURSEMENT:

a. The LME/PIHP shall reimburse CONTRACTOR for services to Enrollees according to the terms and conditions outlined in Article IV of this Contract and as authorized by the LME/PIHP, except in those instance where treatment authorization is not required.
b. The LME/PIHP shall advise the CONTRACTOR of any change in funding patterns that would affect reimbursement to the CONTRACTOR based on availability of the various types of funds.

2. CONFIDENTIALITY:

The LME/ PIHP shall keep confidential, and shall not divulge to any other party, all proprietary, confidential information of CONTRACTOR including, but not limited to, information relating to such matters as finances, methods of operation and competition, pricing, marketing plans and strategies, equipment and operations requirements and information concerning personnel, patients and suppliers, unless such information (i) is or becomes generally available to the public other than as a result of a disclosure by that party, or (ii) is required to be disclosed by law or by a judicial, administrative or regulatory authority.

3. REFERRALS TO CONTRACTOR:

The LME/PIHP may refer Enrollees to CONTRACTOR for services based on medical necessity and the Enrollee's individual choice. The LME/PIHP reserves the right to refer Enrollees to other providers, and no referrals or authorizations are guaranteed to take place under this Contract.

4. UTILIZATION MONITORING:

The LME/PIHP shall monitor and review service utilization data related to the CONTRACTOR and the LME/PIHP's Provider Network to ensure that services are being provided in a manner consistent with Controlling Authority and the LME/PIHP's agreements with the Department.

5. QUALITY ASSURANCE AND QUALITY IMPROVEMENT:

The LME/PIHP shall establish a written program for Quality Assessment and Performance Improvement in accordance with 42 CFR §438.240 that shall include Enrollees, family members and providers through a Global Quality Assurance Committee, and the LME/PIHP shall:

a. Provide CONTRACTOR 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 providers and Enrollee 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 providers.
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 Enrollees.
e. Provide performance feedback to providers including clinical standards and the LME/PIHP expectations.
f. Follow up with CONTRACTOR concerning grievances reported to LME/PIHP by Enrollees.

6. CARE MANAGEMENT/ COORDINATION OF CARE

a. The LME/PIHP shall ensure the coordination of care with each Enrollee's primary care provider and any behavioral health provider enrolled to provide care for each Enrollee. LME/PIHP shall coordinate the discharge of Enrollees with CONTRACTOR to ensure that appropriate services have been arranged following discharge and to link Enrollee with other providers or community assistance.
b. The LME/PIHP shall provide follow up activities to high risk Enrollees discharged from twenty-four hour care.
c. If an Enrollee requires medically necessary MH/DD/SA services, the LME/PIHP shall arrange for Medicaid-reimbursable services for the Enrollee.

7. AUTHORIZATION OF SERVICES:

a. The LME/PIHP shall determine medical necessity for those services requiring prior authorization as set forth in Controlling Authority, including DMA Clinical Coverage Policies.
b. For those services requiring prior authorization, the LME/PIHP shall issue a decision to approve or deny a service within fourteen (14) days after receipt of the request, provided that the deadline may be extended for up to fourteen (14) additional days if:
    1. The Enrollee requests the extension; or
    2. The CONTRACTOR requests the extension; and,
    3. The LME/PIHP justifies to the Department upon request:
        a) A need for additional information; and
        b) How the extension is in the Enrollee's interest.
c. In those cases for services requiring prior authorization in which CONTRACTOR indicates, or LME/PIHP determines, that adherence to the standard timeframe could seriously jeopardize an Enrollee's life or health or ability to attain, maintain, or regain maximum function, including but not limited to psychiatric inpatient hospitalization services, LME/PIHP shall issue a decision to

approve or deny a service within twenty-four (24) hours after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional days if:

1. The Enrollee requests the extension; or
2. The CONTRACTOR requests the extension; and,
3. The LME/PIHP justifies to the Department upon request:
    a) A need for additional information; and
    b) How the extension is in the Enrollee's interest.

d. For those services requiring prior authorization, the LME/PIHP shall permit retroactive authorization of such services in instances where the Enrollee has been retroactively enrolled in the Medicaid program or in the LME/PIHP program, or where the Enrollee has primary insurance which has not yet paid or denied its claim. Retroactive authorizations include requests for deceased Enrollees. The request for authorization must be submitted within ninety (90) days of primary denial or notice of enrollment.

e. Upon the denial of a requested authorization, the LME/PIHP shall inform Enrollee's attending physician or ordering provider of the availability of a peer to peer conversation, to be conducted within one business day.

f. Upon the denial of a requested authorization and peer to peer conversation deadline, the LME/PIHP first level of appeal shall permit the Enrollee or CONTRACTOR to submit additional information to a clinical peer reviewer with the LME/PIHP. The LME/PIHP clinical peer shall determine the correctness of the LME/PIHP's decision to deny the requested authorization. The LME/PIHP clinical peer shall be a clinical peer to the Enrollee's attending physician or ordering provider, hold an active unrestricted license, be board certified, not be involved in the original LME/PIHP decision and not subordinate to the individual who made the original LME/PIHP decision. In instances of a request for authorization of urgent services, the LME/PIHP shall provide verbal notification of an appeal decision within seventy-two (72) hours of the request and shall provide written notification of an appeal decision within three (3) days of the verbal notification. In instance of a request for authorization of non-urgent services, the LME/PIHP shall provide written notification of an appeal decision within thirty (30) days.

g. In conducting prior authorization, LME/PIHP shall not require CONTRACTOR to resubmit any data or documents previously provided to LME/PIHP for the Enrollee's presently authorized services.

ARTICLE IV:
BILLING AND REIMBURSEMENT

1. It is the CONTRACTOR's responsibility to verify the Enrollee's Medicaid coverage prior to submitting claims to the LME/PIHP. If an individual presents for services who is not eligible for Medicaid and the CONTRACTOR reasonably believes that the individual meets Medicaid financial eligibility requirements, CONTRACTOR shall offer to assist the Enrollee in applying for Medicaid.

2. The LME/PIHP Medicaid reimbursement rate can be revised unilaterally by the Department at any time. Should these rates change during the Contract period, the LME/PIHP may seek to negotiate a change in the payment rate.

3. CONTRACTOR shall comply with all terms of this Contract even though a third party agent may be involved in billing the claims to the LME/PIHP. It is a breach of the Contract to assign the right to payment under this Contract to a third party in violation of Controlling Authority, specifically 42 C.F.R. §447.10.

4. CONTRACTOR acknowledges that the LME/PIHP and this Contract covers only those Medicaid-reimbursable MH/DD/SA services listed in Appendix F, and does not cover other services outlined in the North Carolina State Plan for Medical Assistance. The CONTRACTOR may bill any such other services for Medicaid recipients directly to the North Carolina Medicaid program.

5. CONTRACTOR further understands that there are circumstances that may cause an Enrollee to be dis-enrolled from or by the LME/PIHP. If the disenrollment arises from Enrollee's loss of Medicaid eligibility, the LME/PIHP shall be responsible for claims for the Enrollee up to and including the Enrollee's last day of eligibility. If the disenrollment arises from a change in the Enrollee's Medicaid county of residence, LME/PIHP shall be responsible for claims for Enrollee up to the effective date of date of the change in Medicaid county of residence. In any instance of Enrollee's disenrollment, preexisting authorizations will remain valid for any services actually rendered prior to the date of disenrollment.

6. CONTRACTOR shall bill LME/PIHP for all MH/DD/SA services as listed in Appendix F provided to Enrollees who reside in the LME/ PIHP catchment area.

7. LME/PIHP will pay the CONTRACTOR the lesser of the CONTRACTOR's current usual and customary charges or the LME/PIHP established rate for services.

8. <u>SUBMISSION OF CLAIMS</u>

a. 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 the LME/PIHP's secure web based billing system.
b. CONTRACTOR's claims shall be compliant with the National Correct Coding Initiative effective at the date of service.
c. Both parties shall be compliant with the requirements of the National Uniform Billing Committee.
d. Claims for services must be submitted within ninety (90) days of the date of service or discharge (whichever is later), except in the instances denominated in subparagraph 8.e. below. All claims submitted past ninety (90) days of the date of service or discharge (whichever is later) will be denied and cannot be resubmitted except in the instances denominated in subparagraph 8.e. below. LME/PIHP is not responsible for processing or payment of claims that are submitted more than ninety (90) days after the date of service or discharge (whichever is later) except in the instances denominated in subparagraph 8.e. below. The date of receipt is the date the LME/PIHP receives the claim, as indicated on the electronic data records.
e. CONTRACTOR may submit claims subsequent to the ninety (90) day limit in instances where the Enrollee has been retroactively enrolled in the Medicaid program or in the LME/PIHP program, or where the Enrollee has primary insurance which has not yet paid or denied its claim. In such instances, CONTRACTOR may bill the LME/PIHP within ninety (90) days of receipt of notice by the CONTRACTOR of the Enrollee's eligibility for Medicaid and the LME/PIHP, or within 90 days of final action (including payment or denial) by the primary insurance or Medicare the date of service or discharge (whichever is later).

f. If CONTRACTOR delays submission of the claims due to the coordination of benefits, subrogation of benefits or the determination of eligibility for benefits for the Enrollee, CONTRACTOR shall submit such claims within thirty (30) days of the date of the notice of determination of coverage or payment by the third party.
g. If a claim is denied for reasons other than those stated above in subparagraph 8.e. and the CONTRACTOR wishes to resubmit the denied claim with additional information, CONTRACTOR must resubmit the claim within ninety (90) days after CONTRACTOR's receipt of the denial. If the CONTRACTOR needs more than ninety (90) days to resubmit a denied claim, CONTRACTOR must request and receive an extension from the LME/PIHP before the expiration of the ninety (90) deadline, such extension not to be unreasonably withheld.
h. All claims shall be adjudicated as outlined in the LME/PIHP Provider Manual.
i. Billing Diagnosis submitted on claims must be consistent with the service provided.
j. 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 Enrollee, the specific service may be billed as the aggregate of the units delivered rather than as separate line items.
k. The LME/PIHP shall not reimburse CONTRACTOR for "never events."

9. <u>PAYMENT OF CLAIMS</u>

a. LME/PIHP shall reimburse CONTRACTOR for approved Clean Claims for covered services requiring prior authorization within thirty days of the date of receipt. Clean claims for emergency services which do not require prior authorization shall be reimbursed within thirty days of the date of receipt.
b. Within eighteen (18) days after the LME/PIHP receives a claim from CONTRACTOR, the LME/PIHP shall either: (1) approve payment of the claim, (2) deny payment of the claim, or (3) request additional information that is required for making an approval or denial.
    1) If the LME/PIHP denies payment of a claim the LME/PIHP shall provide CONTRACTOR the ability to electronically access the specific denial reason.
    2) "Claims Status" of a claim shall be available within five to seven (5-7) days of the LME/PIHP receiving the claim.
    3) If the LME/PIHP determines that additional information in either original or certified copy form is required for making the approval or denial of the claim, LME/PIHP shall notify the CONTRACTOR within eighteen (18) days after the LME/PIHP received the claim. The CONTRACTOR shall have fifteen (15) days to provide the additional information requested, or the claim shall be denied. Upon LME/PIHP's receipt of the additional information from the CONTRACTOR, the LME/PIHP shall have an additional eighteen (18) days to process the claim as set forth in Paragraph 2, above.
    4) The LME/PIHP is not limited to approving a claim in full or requesting additional information for the entire claim. Rather, as appropriate, the LME/PIHP may approve a claim in part, deny a claim in part, and/or request additional information for only a part of the claim, as long as the LME/PIHP either approves, denies, or requests additional information for each part of the claim within the required eighteen (18) day period.
    5) If LME/PIHP fails to pay CONTRACTOR within these parameters, LME/PIHP shall pay to CONTRACTOR interest in the amount of eight percent of the claim amount beginning on the date following the day on which the payment should have been made.
c. The LME/PIHP will not reimburse CONTRACTOR for services provided by staff not meeting licensure, certification or accreditation requirements.
d. CONTRACTOR understands and agrees that reimbursement rates paid under this Contract are established by the LME/PIHP.

10. <u>THIRD PARTY REIMBURSEMENT</u>

a. CONTRACTOR will comply with N.C.G.S. §122C-146, which requires the LME/PIHP to make every reasonable effort to collect payments from third party payors. Each time an Enrollee receives services CONTRACTOR shall determine if the Enrollee has third party coverage that covers the service provided.

b. CONTRACTOR is required to bill all applicable third party payors prior to billing the LME/PIHP.

1) Medicaid benefits payable through the PIHP 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.
2) The LME/PIHP makes secondary payments to supplement the primary payment if the primary payment is less than the lesser of the usual and customary charges for the service or the rate established by the LME/PIHP.
3) The LME/PIHP does not make a secondary payment if the CONTRACTOR is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.
4) If CONTRACTOR or Enrollee receives a reduced primary payment because of failure to file a proper claim with the primary payor, the LME/PIHP 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.
5) CONTRACTOR must inform the LME/PIHP that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

e. CONTRACTOR shall bill the LME/ PIHP for third party co-pays and/or deductibles only as permitted by Controlling Authority.

11. <u>UNDERPAYMENT/PAYMENTS POST APPEALS:</u>

a. If the LME/PIHP determines that CONTRACTOR has not been paid a claim or a portion of a claim that the LME/PIHP determines should be allowed for any reason, the LME/PIHP shall provide thirty (30) days notice to the CONTRACTOR of the intent to pay the claims or portions of claims. Such notice of action shall identify the Enrollee(s) name and date(s) of service in question, the specific determination made by the LME/PIHP as to each claim, and the amount of payment due to the CONTRACTOR. CONTRACTOR shall have thirty (30) days from date of such notification to appeal the determination of the LME/PIHP. The LME/PIHP shall make such payment within thirty (30) days of the date of the notice of intent to pay claims or portions of claims.

b. Within thirty (30) days of the conclusion of any grievance, appeal or litigation that determines that LME/PIHP improperly failed to pay a claim or a portion of a claim to CONTRACTOR, the LME/PIHP shall remit the amount determined to be owed to CONTRACTOR.

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APPENDICES/ATTACHMENTS:

_____	**Appendix A**	**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS**
_____	**Appendix B**	**CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS**
_____	**Appendix C**	**CERTIFICATION REGARDING LOBBYING**
_____	**Appendix D**	**CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**
_____	**Appendix E**	**MIXED SERVICES PAYMENT PROTOCOL**
_____	**Appendix F**	**AGENCY ADDENDUM**
_____	**Attachment A**	**CONTRACTED SERVICE CODES AND HITECH STATEMENT**
_____	**Attachment B**	**CORE PERFORMANCE INDICATORS FOR**

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Signature Page Between:
PARTNERS BEHAVIORAL HEALTH MANAGEMENT

and

[Company]

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

[Company]

_____ _____
Legally Authorized Representative Date

Printed Name: _____

Title: _____

[Company Address]

[Company Phone]

Contact:

Tax ID:

PARTNERS BEHAVIORAL HEALTH MANAGEMENT

_____ _____
Legally Authorized Representative Date
W. Rhett Melton
Chief Executive Officer

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

_____ _____
Legally Authorized Representative Date
Susan Lackey
Chief Finance Officer

APPENDIX A

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

(Note: The phrase "prospective lower tier participant" means providers under contract with the Division.)

Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom the proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

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

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

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

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

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions

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

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

_____ _____

Signature Title

_____ _____

Agency/Organization Date

(Certification signature should be same as Contract signature).

APPENDIX B

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

I. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing a drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) The Contractor's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph A;

D. Notifying the employee in the statement required by paragraph A that, as a condition of employment under the agreement, the employee will:
(1) Abide by the terms of the statement; and

(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

E. Notifying the Department within ten days after receiving notice under subparagraph D(2) from an employee or otherwise receiving actual notice of such conviction;

F. Taking one of the following actions, within 30 days of receiving notice under subparagraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(3) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

II. The site(s) for the performance of work done in connection with the specific agreement are listed below:

1._____
(Street address)

_____
(City, county, state, zip code)

2._____
(Street address)

_____
(City, county, state, zip code)

Contractor will inform the Department of any additional sites for performance of work under this agreement.

False certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment, 45 C.F.R. 82.510.

_____ _____
Signature Title

_____ _____
Agency/Organization Date
(Certification signature should be same as Contract signature).

APPENDIX C

Certification Regarding Lobbying
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Certification for Contracts, Grants, Loans and Cooperative Agreements

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

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any Federal, state or local government agency, a Member of Congress, a Member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a Member of Congress, or an employee of a Member of the General Assembly in connection with the awarding of any Federal or state contract, the making of any Federal or state grant, the making of any Federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or state contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any Federal, state or local government agency, a Member of Congress, a Member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a Member of Congress, or an employee of a Member of the General Assembly in connection with the awarding of any Federal or state contract, the making of any Federal or state grant, the making of any Federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or state contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Notwithstanding other provisions of federal OMB Circulars A-122 and A-87, costs associated with the following activities are unallowable:

Paragraph A.

(1) Attempts to influence the outcomes of any Federal, State, or local election, referendum, initiative, or similar procedure, through in kind or cash contributions, endorsements, publicity, or similar activity;

(2) Establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;

(3) Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation through communication with any member or employee of the Congress or State legislature (including efforts to influence State or local officials to engage in similar lobbying activity), or with any Government official or employee in connection with a decision to sign or veto enrolled legislation;

(4) Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation by preparing, distributing or using publicity or propaganda, or by urging members of the general public or any segment thereof to contribute to or participate in any mass demonstration, march, rally, fundraising drive, lobbying campaign or letter writing or telephone campaign; or
(5) Legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

The following activities as enumerated in Paragraph B are excepted from the coverage of Paragraph A:

Paragraph B.

(1) Providing a technical and factual presentation of information on a topic directly related to the performance of a grant, contract or other agreement through hearing testimony, statements or letters to the Congress or a State legislature, or subdivision, member, or cognizant staff member thereof, in response to a documented request (including a Congressional Record notice requesting testimony or statements for the record at a regularly scheduled hearing) made by the recipient member, legislative body or subdivision, or a cognizant staff member thereof; provided such information is readily obtainable and can be readily put in deliverable form; and further provided that costs under this section for travel, lodging or meals are unallowable unless incurred to offer testimony at a regularly scheduled Congressional hearing pursuant to a written request for such presentation made by the Chairman or Ranking Minority Member of the Committee or Subcommittee conducting such hearing.
(2) Any lobbying made unallowable by subparagraph A(3) to influence State legislation in order to directly reduce the cost, or to avoid material impairment of the organization's authority to perform the grant, contract, or other agreement.
(3) Any activity specifically authorized by statute to be undertaken with funds from the grant, contract, or other agreement.

Paragraph C.

(1) When an organization seeks reimbursement for indirect costs, total lobbying costs shall be separately identified in the indirect cost rate proposal, and thereafter treated as other unallowable activity costs in accordance with the procedures of subparagraph B(3).
(2) Organizations shall submit, as part of the annual indirect cost rate proposal, a certification that the requirements and standards of this paragraph have been complied with.
(3) Organizations shall maintain adequate records to demonstrate that the determination of costs as being allowable or unallowable pursuant to this section complies with the requirements of this Circular.
(4) Time logs, calendars, or similar records shall not be required to be created for purposes of complying with this paragraph during any particular calendar month when: (i) the employee engages in lobbying (as defined in subparagraphs A & B) 25 percent or less of the employee's compensated hours of employment during that calendar month, and (ii) within the preceding five-year period, the organization has not materially misstated allowable or unallowable costs of any nature, including legislative lobbying costs. When conditions (i) and (ii) are met, organizations are not required to establish records to support the allow ability of claimed costs in addition to records already required or maintained. Also, when conditions (i) and (ii) are met, the absence of time logs, calendars, or similar records will not serve as a basis for disallowing costs by contesting estimates of lobbying time spent by employees during a calendar month.
(5) Agencies shall establish procedures for resolving in advance, in consultation with OMB, any significant questions or disagreements concerning the interpretation or application of this section. Any such advance resolution shall be binding in any subsequent settlements, audits or investigations with respect to that grant or contract for purposes of interpretation of this Circular; provided, however, that this shall

not be construed to prevent a contractor or grantee from contesting the lawfulness of such a determination.

Paragraph D.
Executive lobbying costs. Costs incurred in attempting to improperly influence either directly or indirectly, an employee or officer of the Executive Branch of the Federal Government to give consideration or to act regarding a sponsored agreement or a regulatory matter are unallowable. Improper influence means any influence that induces or tends to induce a Federal employee or officer to give consideration or to act regarding a federally sponsored agreement or regulatory matter on any basis other than the merits of the matter.

_____ _____
Signature Title

_____ _____
Agency/Organization Date
(Certification signature should be same as Contract signature.)

APPENDIX D

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Certification for Contracts, Grants, Loans and Cooperative Agreements

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

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

_____ _____
Signature Title

_____ _____
Agency/Organization Date
(Certification signature should be same as Contract signature).

APPENDIX E
MIXED SERVICES PAYMENT PROTOCOL

Services	Claim Processing and/or Financial Liability
Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRGs)	**LME/PIHP**
Outpatient X-ray and Lab Work	**DMA fee-for-service Medicaid except when provided during emergency room visits where the primary diagnosis is in the following range: F01-F99**
Prescribed by an LME/PIHP network provider on an Inpatient basis such as VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.	**DMA fee-for-service Medicaid fee-for-service Medicaid except when provided during emergency room visits where the primary diagnosis is in the following range: F01-F99**
Prescribed by LME/PIHP network provider on an outpatient basis such as therapeutic drug levels.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: F01-F99**
Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: F01-F99**
Other tests ordered by non-LME/PIHP physician	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: F01-F99**
Drugs	
Outpatient prescription drugs and take-home drugs.	DMA fee-for-service Medicaid
Ambulance	
Transport to the hospital when the primary diagnosis is behavioral care	DMA fee-for-service Medicaid
Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	DMA fee-for-service Medicaid
Transfers authorized by LME/PIHP from non-network facility to a network facility	LME/PIHP
Consults	
Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit	LME/PIHP
Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	LME/PIHP
Medical/Surgical on Mental Health/Substance Abuse Unit	DMA fee-for-service Medicaid
Emergency Room Charges — Professional Services	
Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	LME/PIHP
Emergency room services **where the primary diagnosis on the claim is in the following range: F01-F99**	LME/PIHP

Services	Claim Processing and/or Financial Liability
Emergency Room Facility Charge	
Emergency room services **where the primary diagnosis on the claim is in the following range: F01-F99**	LME/PIHP
Emergency room services **where the primary diagnosis on the claim is NOT in the following range: F01-F99**	DMA fee-for-service Medicaid
Medical/Neurological/Organic Issues	
Stabilization of self-induced trauma poisoning	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: F01-F99**
Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: F01-F99**
Miscellaneous	
Pre-Authorized, Mental Health, Alcohol/Substance Abuse admission, History and Physical	LME/PIHP
Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or LME/PIHP authorized physician	LME/PIHP
Alcohol Withdrawal Syndrome and Delirium Tremens	
Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by elevated vital signs, agitation, perspiration, anxiety and tremor that is associated with the abrupt cessation of alcohol or other Addictive substances. Detoxification services authorized by LME/PIHP. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs except when services are provided in the emergency room and the primary diagnosis is in the following range: F01-F99.	LME/PIHP
Delirium tremens (DTs), which is a complication of chronic alcoholism associated with poor nutritional status. This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: F01-F99**

APPENDIX F

AGENCY ADDENDUM

PROCUREMENT CONTRACT FOR PROVISION OF SERVICES
BETWEEN
PARTNERS BEHAVIORAL HEALTH MANAGEMENT
LME/PIHP
AND
[Company]
A PROVIDER OF MH/DD/SA SERVICES

1. **DISCLOSURES AND ENROLLMENT:**
   a. The CONTRACTOR must disclose any affiliation, by contract or otherwise, with any other provider agency, or independent contractor to perform any of the duties, responsibilities or obligations of this Contract. The CONTRACTOR must disclose whether it is doing business using a DBA (doing business as).
   b. The CONTRACTOR must report to the LME/PIHP any sanctions under the Medicare or Medicaid programs, including but not limited to overpayments, recoupments, fines, paybacks, suspensions, terminations, lawsuits, insurance claims, or payouts, as well as any adverse actions by federal or state regulatory agencies within the previous five (5) years.
   c. The CONTRACTOR'S Licensed Independent Practitioners (LIPs) and Licensed Practitioner Associates (LPA's) can be reimbursed for services to Enrollee(s) upon approval by the LME/PIHP of the LIP's and LPA's completed "LME/PIHP Uniform Application to Participate as a Health Care Practitioner" retroactive to the date of receipt of the completed application by the LME/PIHP.
2. **DELIVERY OF SERVICES:**
   a. CONTRACTOR is required to serve Enrollees within sixty (60) calendar days from the date of execution of this Contract. If CONTRACTOR has not accepted and delivered services to Enrollees within sixty (60) calendar days from the date of execution of this Contract, the CONTRACT shall be terminated without further notice.
   b. Service Availability Requirements: 1) Emergency: within two (2) hours or immediate for life threatening emergency; 2) Urgent: within forty-eight (48) hours; and 3) Routine: within fourteen (14) days.
3. **CARE COORDINATION:**
   a. CONTRACTOR shall allow LME care coordination staff direct access to Enrollee(s) served under this Contract. CONTRACTOR shall allow designated LME care coordination staff to attend any treatment team and discharge planning meetings regarding Enrollee(s) served under this Contract, with advanced notice and consistent with the LME's responsibility to provide care coordination to Enrollee(s) with special healthcare needs.
   b. Upon request of LME/PIHP, CONTRACTOR shall designate qualified care coordination staff to participate in interdisciplinary team meetings facilitated by the LME/PIHP that involve Enrollee(s) served under this Contract.
   c. CONTRACTOR 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 Abuse Disorder, or shall directly participate in the planning process.

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

4. RESTRICTIVE INTERVENTIONS:

When a restrictive intervention is used CONTRACTOR shall follow all applicable Controlling Authority governing the use of restrictive interventions.

5. ACCESS TO FACILITIES AND RECORDS:

CONTRACTOR agrees and understands that the LME/PIHP may inspect CONTRACTOR's facilities or premises where documents are stored or Enrollees are served to ensure compliance with Controlling Authority.

6. DUTIES RELATED TO CLOSURE OR TERMINATION:

a. CONTRACTOR shall provide at least thirty (30) days' notice of closure of CONTRACTOR's network operations to LME/PIHP.

b. Upon closure of the CONTRACTOR'S network operations or termination of this contract, regardless of the reason, the following shall apply:

   i. CONTRACTOR must provide a copy of all records for Enrollees served under this Contract to the LME/PIHP within sixty (60) days;

   ii. In the alternative, CONTRACTOR may submit a plan for maintenance and storage of all records for approval by the LME/PIHP. The LME/PIHP has the sole discretion to approve or disapprove such plan;

   iii. Records shall include but not be limited to: a minimum of progress notes that inform of the most recent contacts with an Enrollee, any information related to the CONTRACTOR's efforts to engage the Enrollee with an alternate provider of his/her choice, medication management information, a copy of the most recent comprehensive clinical assessment, a copy of the most recent PCP/ ISP updates, any psychiatric or psychological evaluations, up to date demographic information, and any other records required to be maintained by Controlling Authority.

c. CONTRACTOR shall comply with North Carolina Continuity of Care requirements as set forth in N.C.G.S. §122C-63 which requires sixty (60) days' notice by the CONTRACTOR to the LME/PIHP of intent to close a facility or discharge an Enrollee with intellectual or developmental disabilities who may be in need of continuing care as determined by the LME/PIHP.

d. CONTRACTOR shall provide thirty (30) days' of intent to close a facility or discharge an Enrollee with a mental illness or substance abuse disorder who may be in need of continuing care as determined by the LME/PIHP.

7. ENROLLEE GRIEVANCES:

The LME/PIHP's Anonymous Concern and Complaint line must be published and made available to Enrollees and family members.

8. DOCUMENTATION REQUIREMENTS:

CONTRACTOR shall document all services provided and must assure that the documentation is in compliance with Controlling Authority and the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Records Management and Documentation Manual for Providers of Publicly-Funded MH./DD/SA Services (APSM 45-2), and Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services (APSM 30-1).

9. INSURANCE:

a. CONTRACTOR 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.

i. Professional Liability: The CONTRACTOR shall purchase and maintain Professional Liability Insurance protecting the CONTRACTOR and any employee performing work under the Contract for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate. In the event that the CONTRACTOR discovers that a claim, suit of criminal/administrative proceeding has been brought or may be brought against the CONTRACTOR and/or Practitioner relating to the quality of services provided under this Agreement, then CONTRACTOR shall notify LME within ten (10) days and LME will determine whether to terminate this Agreement.

ii. Comprehensive General Liability: The CONTRACTOR shall purchase and maintain Bodily Injury and Property Damage Liability Insurance protecting the CONTRACTOR 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/$1,000,000.00 Personal and Advertising Injury/$50,000.00 Fire Damage. The insurance shall not include exclusion for contractual liability.

iii. Automobile Liability: If CONTRACTOR transports recipients, the CONTRACTOR shall purchase and maintain Automobile Bodily Injury and Property Damage Liability Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for limits of not less than $1,000,000.00 each person and $1,000,000.00 each occurrence of Bodily Injury Liability and $1,000,000.00 each occurrence of Property Damage Liability. Policies written on a combined single limit basis should have a limit of not less than $1,000,000.00.

iv. Workers' Compensation and Occupational Disease Insurance, Employer's Liability Insurance: The CONTRACTOR shall purchase and maintain Workers' Compensation and Occupational Disease Insurance as required by the statutes of the State of North Carolina. The CONTRACTOR shall purchase and maintain 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.

v. 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.

vi. Waivers of Subrogation: Contractor shall obtain and provide to the LME waivers from Contractor's workers compensation and occupational disease and commercial general liability carriers of any right of recovery that such liability carriers may have because of payments made by them for injury or damage arising out of work done by the Contractor under this Contract, including Contract documents issued under this Contract such as a Service Authorization Request.

b. Any CONTRACTOR 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 DMA and LME/PIHP Contract and Innovations Waiver §1915(c) rules.

c. CONTRACTOR shall:
   i. Provide to the LME/PIHP with Certificate(s) of Insurance (COI) or Change Endorsement(s) with the LME/PIHP named as an Additional Insured prior to the LME/PIHP's execution of the Contract, except that Licensed Independent Professionals are not required to comply with this requirement;
   ii. Submit new COIs no later than ten (10) calendar days after the expiration of any listed policy to ensure documentation of continual coverage;
   iii. Notify the LME/PIHP in writing within forty-eight (48) calendar hours of any cancellation or material change in coverage;
   iv. Provide evidence to the LME/PIHP of continual coverage at the levels stated above within forty-eight (48) calendar hours if CONTRACTOR changes insurance carriers during the performance period of the Contract including tail coverage as required for continual coverage; and
   v. Notify the LME/PIHP in writing within forty-eight (48) calendar hours of knowledge or notice of a claim, suit, criminal or administrative proceeding against CONTRACTOR and/or Practitioner relating to the quality of services provided under this Contract.

d. CONTRACTOR shall have the right to self-insure provided that CONTRACTOR's self-Insurance program is licensed 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.

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

ATTACHMENT A

LIST OF CONTRACTED SERVICE CODES

All services listed will be reimbursed at the current Division published rate. Rates are subject to change automatically upon action by the NC General Assembly, NC Division of Medical Assistance, or the NC Division of MH/DD/SA. It is the responsibility of Contractor to monitor rates. No written notice to Contractor will occur when and if rate changes occur. Providers must bill appropriately for any codes that are discontinued or end-dated by the state during this contract period.

[Company]

SERVICE CODE and DESCRIPTION

Provider hereby agrees to fully comply with all requirements pursuant to Health Insurance Portability and Accountability Act of 1996, as modified and amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), as well as related Federal regulations including but not limited to the Omnibus Final Rule effective 2013. Failure to comply may result in the termination of this contractual agreement between Partners BHM and Provider.

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

1. Providers shall be responsible for full participation in an LME-MCO monitoring/review process that includes the Division of MH/DD/SA Confidence Assessment Criteria and the Local Monitoring discussion guide. Frequency of reviews and corrective requirements are determined by demonstration of acceptable compliance with quality indicators and scores from the Confidence Assessment.

2. 100% of all Level I Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported/documented internally by the Provider, and reported in aggregate form quarterly to the LME-MCO.

3. At least 85% of all Level II Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported to the LME-MCO and the Department within 72 hours via the *DHHS Incident & Death Form*. An aggregate total for the quarter will be part of the Provider's quarterly report to the LME-MCO.
4. At least 85% of all Level III Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported verbally immediately to the LME-MCO, and in written form to the LME-MCO and the Department within 72 hours via the DHHS Incident & Death Form. The Provider shall convene an incident review committee within 24 hours. Deaths that occur within 7 days of seclusion or restraint are reported immediately to the LME-MCO. An aggregate total for the quarter will be part of the Provider's quarterly report to the LME-MCO.

5. 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 Area Program/County Program Quality Management Department, and show evidence of being acted upon.

6. 100% of quality of care issues, as noted through Area Authority 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 in the LME-MCO's Quality Management Plan.

7. 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 twice a year. Survey results are submitted to the LME-MCO. Providers may meet this requirement by full participation in the LME-MCO's Quarterly Consumer Satisfaction Survey. The Provider is also required to participate in the Division of MH/DD/SAS's annual Consumer Satisfaction Survey.

8. When applicable, Providers shall meet no less than 85% of established time frames for initial face-to-face consumer contact (Emergent: within 2 hours; Urgent: within 48 hours; Routine: 14 calendar days.).

9. Providers shall meet 100% compliance with Operations Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS). As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers and families).

10. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the LME-MCO in any quarter of completion.

11. Providers shall comply with current North Carolina E-Verify laws.

12. Partners has adopted the following measures for integration into provider contracts beginning July 1, 2015. We have been able to complete a baseline review since January 1, 2015 and the above measures have been tested for validity.

Domain	Outcome	Measures
1. Claims Accuracy	Increase Provider Claims Approval Rate	Provider must have a claims approval rate at or above 80% in each quarter of the fiscal year per funding source. (applies to provider specific denial reasons, not LME/MCO issues)
2. UM Authorizations Approval	Increase Authorization Approval Rates	Provider must demonstrate an authorization approval rate on service requests is at or above 75% during the Partners' identified quarter of each fiscal year (example, July, August, September 2015) –across all services and all providers
3. NCTOPPs Compliance	Increased timeliness of 3 month interview submissions	95% of all Provider 3 month interview submissions will be in compliance with timely submission requirements. ***(for all providers required to submit NCTOPPs and for the services that required NC TOPPs submission)***

Partners Behavioral Health Management

SPECIFIC SERVICE DELIVERY PERFORMANCE INDICATORS

***Subject*:** Information Exchange Between Partners BHM & Providers
Purpose: Communication expectations ensure that required grant, financial & other County, State, and/or Federal reporting information is made available to the LME-MCO and other applicable parties.

SPECIFIC SERVICE DELIVERY PERFORMANCE INDICATORS

I. Financial

A. Accounting and Claims Processing:

1) Provider must maintain an accounting and claims processing system compliant with G.S. 159-26 and shall have proper internal controls to ensure proper record keeping and generally accepted accounting procedures are continually in place.

2) Provider must have a system in place that allows an audit to be completed for consumer accounts. In the event an overpayment of funds is found during an audit, the Provider must repay said funds within 30 days to LME-MCO.

B. Billing

Consumers eligible for Medicaid are not eligible to receive IPRS/State Funding. IPRS funds are a payer of last resort. Providers must collect first and third party revenue. The Provider must have a system in place to monitor such activity and subsequently repay any related amounts to consumers.

II. Best Practice Model

A. Provide/coordinate psychiatric services along with clinical home for these consumers if in the person-centered plan.

B. Assure all consumers have choice of provider and these processes are followed for transition of consumers as well as referrals.

C. Providers must fully comply with First Responder duties.

III. Committee Participation

A. Partners would like the Provider to attend or actively participate in the Community Collaborative process for children's families and attend work groups or committees as invited by the LME-MCO.

IV. Authorizations

A. Providers will comply with the following regarding service authorizations.
- **1)** Submit authorization requests at least 14 days before the end of an existing authorization.
- **2)** Limit request(s) to service type, scope and duration that is medically necessary and consistent with IPRS benefit grids.
- **3)** Submit all documentation that is requested by the LME-MCO staff to conduct Utilization Review within timeframes communicated.

In order for Partners Behavioral Health Management to report pertinent information to federal, state and local authorities (as mandated by various contracts and agreements), providers are expected to submit the data listed below according to the related timelines. In order to ensure timely payment, all required information must be submitted as detailed below.

Providers will acknowledge all referrals (accept the referral) made to them via the Slot Scheduler via Provider Portal within 24 hours or next business day, by checking the acknowledgement checkbox in the referral.

If a Provider is unable to acknowledge (accept) the referral they will email Customer Services at AccessStaff@partnersbhm.org and inform Customer Services that the consumer will need to be scheduled with another provider and why.

Areas of reporting include (where applicable), but are not necessarily limited to:

Reporting Requirement	Applicable Service	Submission Timeline
After-care Planning w/ State Operated Facilities		Day After No Show
CARF (Applies to Non-Accredited Providers)		As Requested
Client Movement Report	All	Each occurrence
Complete Admissions Data	All	Enrollment / Authorization
Complete Diagnostic Data	All	Enrollment / Authorization
Complete Drug of Choice Data	All	Enrollment / Authorization
Complete ID & Demographic Data	All	Enrollment / Authorization
Continuous Quality Improvements (CQI) Projects	All	3 Per Year, or as mandated by Division and/or accreditation
Death Reports: Level II	All	Within 72 hours
Death Reports: Level III	All	Immediate verbal/written w/i 24 hrs
Diversion Law (MR consumers)		At Placement
DSS Referrals	All	As Referred
Financial & Annual Statement	All	Annually; after each official audit
Housing Programs		March 7th
JCPC Client Tracking Form		Enrollment / Authorization
JCPC Semi-Annual Report		January 10th & July 10th
Juvenile Court Services Referrals		As Referred
Level I Incident Reports	All	Quarterly by 10th of month
Level II Incident Reports	All	Within 72 hours of Incident
Level III Incident Reports	All	Immediate verbal/written w/I 72 hrs
MAJORS Report / JJSAMHP	MAJORS	Monthly by the 10th
National Core Indicators	DD Providers	2nd / 3rd Qtr - As Scheduled
NC-SNAP	DD Providers	Enrollment / Yearly
NC-TOPPS Transfer/Discharge	MH & SA Providers	At Transfer/Discharge
NC-TOPPS Initial	MH & SA Providers	Within 30 days of First Service (New) In conjunction with PCP Update (Current)
NC-TOPPS Update	MH & SA providers	As Scheduled
No Missing Data	All	Enrollment / Authorization
No Unknown Data	All	Enrollment / Authorization
Out of Home Community Placement	All	At Placement
Quality Improvement Practices and Outcomes	All	As Requested
Restrictive Intervention Reports	All	Within 72 hours of Incident
SAPTBG Compliance Report	SA Providers	January 10th & July 10th
Service Information – Audits	All	As Requested
State Consumer Satisfaction Survey	All	1st Qtr. - As Scheduled
State/Federal Funding MH Adult Reports: (PATH, MH Block Grant, SAPTBG, etc.)	Homelessness, SA Providers	January 10th & July 10th
Work First	Work First-SA	Quarterly by 10th of month
Urgent and Routine No Show List	All	Daily
Weapon's Permit Information		As Requested

Emergent-Client Specific	Urgent-Client Specific	Routine-Client Specific
Who was seen within 2 hours of referral from Clinical Services	Who was seen within 48 hours of Clinical Services referral	Who was seen within 14 days of Clinical Services referral
Who could have been seen but consumer decided not to show up until later	Who could have been seen but consumer decided not to show until later or declined an appointment until later	Who could have been seen but consumer decided not to show until later or declined an appointment until later
Who could not be seen within two hours because Provider had no availability of services	Who could not be seen within 48 hours because Provider had no availability of services	Who could not be seen within fourteen days because Provider had no availability of services
Who did not show at all	Who did not show at all	Who did not show at all