Transforming Lives.
Building Community Well-Being.

Trillium HEALTH RESOURCES

Procurement Contract Quick Reference Guide

What's Changed?

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FULL

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Purpose

To meet the Department's requirements and align with their expectations for provider contracting as a Tailored Plan, Trillium made revisions to the current Procurement Contract for the Provision of Services (Provider Contract) template. Using the Tailored Plan RFP as a guide, the current Contract was revised, submitted to the Department, and approved for use.

In an effort to aid providers in their review of the terms and conditions that will be effective beginning December 1, 2022, we created this Quick Reference Guide. While this guide does not include every edit, it does highlight changes that have the potential to increase provider abrasion for meeting contracting requirements, service delivery, claims, and reimbursement.

If you have questions about the information contained in this Quick Reference Guide or the contracting process, please submit your questions and/or feedback to Contracts or call the Provider Support Service Line at 1-855-250-1539.

Current Provider Contract	Tailored Plan Provider Contract
TERM: The term of this Contract shall have an effective date of MONTH DAY, YEAR, and shall remain in effect for no more than three (3) years from the effective date, or MONTH DAY, YEAR, unless terminated by either party as set forth herein.	**TERM:** This Contract is effective December 1, 2022 to June 30, 2023 and shall auto-renew annually on July 1 of each year thereafter. Either party may notify the other no less than sixty (60) days prior to July 1 of the current contract year if they do not wish to auto-renew for an additional term
N/A	**ARTICLE I.2.B.**: Department authority related to the Medicaid Program. The Contractor agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.
N/A	**ARTICLE 1.4.B**.: Compliance with state and federal laws. The Contractor understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement Contracts, or other court orders that apply to the Contract and the BH I/DD Tailored Plans Managed Care and State funded Services contract with NC DHHS, and all persons or entities receiving state and federal funds. The Contractor understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Contract, or any violation of the BH I/DD Tailored Plan's contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
N/A	**ARTICLE I.4.C**.: Compliance with state laws. The Contractor understands and agrees that it is subject to all state laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the BH I/DD Tailored Plan's State-funded Services contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state funds. The Contractor understands and agrees that any violation by a provider of a state law relating to the delivery of services pursuant to this contract, or any violation of the BH I/DD Tailored Plans contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under Federal or state law.
N/A	**ARTICLE II.8.F**: Non-Discrimination Equitable Treatment of Members. The Contractor agrees to render provider services to Members with the same degree of care and skills as customarily provided to the Contractors patients who are not members, according to generally accepted standards of medical practice. The Contractor agrees that members and non-members should be treated equitably. The Contractor agrees not to discriminate against members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
N/A	**ARTICLE 11.11.a-c**.: Contractor has an obligation to arrange for call coverage or other back-up to provide services in accordance with the BH I/DD Tailored Plan's standards to ensure service accessibility. The Contractor shall: a. Offer hours of operation that are no less than the hours of operation offered to Members or comparable to NC Medicaid Direct, if the Contractor serves only Medicaid beneficiaries; b. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and c. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Contractor will accept all referrals meeting criteria for services negotiated, approved by BH I/DD Tailored Plan, and offered by Contractor when there is available capacity.

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N/A	**ARTICLE III.1.A:** BH I/DD Tailored Plan will provide a mechanism that allows Contractor to verify member eligibility before rendering services and reporting of eligibility information to the BH I/DD Tailored Plan.
N/A	**ARTICLE IV.1.J-K.:** J. Member Billing. Contractor must notify any Member ahead of time and shall not bill the member for covered services, except for agreed upon specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit Contractor and Member from agreeing to continue non-covered services at the member's own expense, as long as the Contractor has notified the Member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the Member to receive the service. K. Hold Member Harmless. The Contractor agrees to hold the Member harmless for charges for any covered service. The Contractor agrees not to bill a Member for medically necessary services covered by the BH I/DD Tailored Plan so long as the Member is eligible for coverage.
ARTICLE IV: BILLING AND REIMBURSEMENT **Review all of this section closely as multiple changes were made. The below only represents a portion of these changes.** **ARTICLE IV.1.D&E.:** 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 Member has been retroactively enrolled in the Medicaid program or in the LME/PIHP program, or where the Member 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 Member'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).	**ARTICLE IV: BILLING AND REIMBURSEMENT** **Review all of this section closely as multiple changes and additions were made. The below only represents a portion of these changes.** **ARTICLE IV.2.G.:** G.S. 58-3-225. Prompt claim payments under health benefits. The Contractor shall submit all claims to the BH I/DD Tailored Plan for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the Contractor's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the Contractor to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.
ARTICLE II.3.B.: Contractor shall report all events or instances involving abuse, neglect or exploitation of Member(s) as required by incident reporting guidelines by all applicable agencies and the Controlling Authority.	**ARTICLE II.3.B.:** Contractor will comply with applicable critical incident and death reporting laws, regulations, policies, and event reporting requirements of national accreditation organizations to include reporting of all events or instances involving abuse, neglect or exploitation of Member as required by incident reporting guidelines by all applicable agencies and the Controlling Authority.

Current Provider Contract	Tailored Plan Provider Contract
ARTICLE II.18.: INSURANCE: Contractor shall, as a material condition of this Contract obtain and continuously maintain a. General Liability Insurance; b. Automobile Liability Insurance; c. Worker's Compensation Insurance; d. Employer's Liability Insurance; and/or e. Professional Liability Insurance; as specified in Appendix G. LME/PIHP reserves the right to review its insurance limits annually and revise them as needed. Contractor shall obtain coverage that may only be suspended, voided, canceled or reduced by the carrier upon thirty (30) days prior written notice to Contractor, which written notice shall be forwarded by Contractor to LME/PIHP within five (5) business days. Contractor shall submit certificates of coverage to LME/PIHP. Upon DHB's request, LME/PIHP shall submit copies of these certificates to DHB. **APPENDIX G.4.INSURANCE:** **Insurance Requirements have changed and coverages vary depending on business type of the Contractor.**	**ARTICLE II.18.A&B.:** A. The Contractor shall purchase and maintain Professional Liability Insurance as listed below from a company, or a self-insurance program that is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Self-insurance policies shall not be eliminated or reduced in coverage or limits below the stated minimums without thirty (30) days prior notice to the BH I/DD Tailored Plan. i. Professional Liability. The Contractor shall purchase and maintain professional liability insurance protecting the Contractor and any employee performing work under the Contract for an amount of not less than $1,000,000.00 per occurrence and proof of coverage at or exceeding $3,000,000.00 in the annual aggregate. B. Contractor shall, purchase and maintain additional insurance coverage as specified in Appendix F. BH I/DD Tailored Plan reserves the right to review its insurance limits annually and revise them as needed. Contractor shall obtain coverage that may only be suspended, voided, canceled or reduced by the carrier upon thirty (30) days prior written notice to Contractor, which written notice shall be forwarded by Contractor to BH I/DD Tailored Plan within five (5) business days. Upon request, Contractor shall submit certificates of coverage to BH I/DD Tailored Plan. Upon DHB's request, BH I/DD Tailored Plan shall submit copies of these certificates to DHB. Contractor acknowledges that: i. Any loss of insurance shall justify the termination of this Contract in the BH I/DD Tailored Plan's sole discretion; ii. Upon Contractor's notification of knowledge or notice of a claim, suit, criminal or administrative proceeding against Contractor and/or Practitioner relating to the quality of services provided under this Contract, BH I/DD Tailored Plan in its sole discretion shall determine within ten (10) days of receipt of notification whether termination of the Contract or other sanction is required; and iii. All insurance requirements of this Contract shall be fully met unless specifically waived in writing by both the BH I/DD Tailored Plan and Contractor. **APPENDIX F.4.INSURANCE** **The following outlines the insurance coverages required for contracting with a Tailored Plan.** • **Practitioners –** 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 a Contract to continue liability coverage with a retroactive date on or before the beginning of the contract term, shall also be provided. • **Agency** – No additional coverages specified • **Intermediate Care Facility (ICF)** – No additional coverages specified • **Hospital** – No additional coverages specified

Current Provider Contract	Tailored Plan Provider Contract
APPENDIX G.HOSPTIAL ADDENDUM.8.AUTHORIZATION OF SERVICES: In those cases for services requiring prior authorization for inpatient hospitalization, 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 twenty-four (24) hours if: A. The Member requests the extension; or B. The Contractor requests the extension; and, C. The LME/PIHP justifies to the Department upon request: i. A need for additional information; and ii. How the extension is in the Member's interest.	**APPENDIX F.HOSPTIAL ADDENDUM.7.AUTHORIZATION OF SERVICES:** In those cases for services requiring prior authorization for inpatient hospitalization, BH I/DD Tailored Plan shall issue a decision to approve or deny a service within seventy two (72) hours after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional calendar days if: i. The Member requests the extension; or ii. The Contractor requests the extension; and, iii. The BH I/DD Tailored Plan justifies to the Department upon request: a) A need for additional information; and b) How the extension is in the Member's interest.
N/A	**APPENDIX F.HOSPTIAL ADDENDUM.11.FOLLOW UP AFTER DISCHARGE:** Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care. Discharge planning begins at admission. Effective discharge planning must include collaboration with the family, caregiver or legally responsible person, their informal and natural supports and the PIHP, as well as other agencies involved (such as schools, Social Services, Juvenile Justice, other treatment providers) as appropriate. For a member who is engaged in receiving services from another community-based provider, the Contractor must involve the community-based provider in treatment, discharge planning, and schedule an aftercare appointment within 1-7 days of discharge.

TP PROVIDER CONTRACT
FAQ'S & OTHER INFORMATION

ALSO NEW FOR THE TP PROVIDER CONTRACT:

- Additional attachments will be issued for signature when applicable:
  - Attachment B: Deficit Reduction Act
  - Attachment C: Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members
  - Attachment D: Pregnancy Management Program Policy for Medicaid and NC Health Choice Members
  - Attachment E: Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
  - Attachment F: Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members
  - Attachment G: Indian Health Care Providers

CONTRACTING PROCESS:

The Tailored Plan contracting process will follow a Good Faith Contracting Policy. This process includes 3 attempts. If a potential contractor does not respond or acknowledge receipt of the contract or attempts to contract within 30 days, the contracting process can be terminated. It is important to provide the correct contact phone and email for this to occur.

- Day 1 [First Attempt] – Verbal
- Day 10 [Second Attempt] – Written
- Day 20 [Third Attempt] – Verbal

Can the language in the TP Provider Contract be negotiated?

- While some of the language can be negotiated, most of the additional language is required by the Department to be verbatim.