

Operations Manual

Western Highlands
Area Authority

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OPERATIONS MANUAL

INTRODUCTION

This manual is a binding part of the Agreement or contract between the Area Authority and providers of Medicaid and State Funded services. The intent of this manual is to reference detailed information and where possible require the same statewide procedures as part of any agreement or contract between an Area Authority/County Program and a provider agency.

This manual does not include information about DHHS endorsement procedures that take place prior to any agreement with a Medicaid Provider. Rather, it includes only information pertinent to the performance of the Agreement or contract, whichever applies.

Information or procedures which pertain only to Medicaid providers or only to State Funded providers are identified. The absence of this designation Medicaid or State Funded means that the information or source document pertains to both types of providers. References to the Area Authority/County Program policy and procedures mean that the local AREA AUTHORITY may insert their own information and that statewide applications do not apply at this time.

OUR MISSION:

To ensure the provision of high quality, consumer responsive, culturally sensitive, and cost-effective services to those who are living with mental illness, developmental disabilities, and substance abuse. We are committed to flexible, accessible, family-centered services that honor the dignity, respect the rights and maximize the potential of the individual.

Western Highlands will ensure the development and management of a comprehensive network of community services and supports for people with mental illness, substance abuse, and developmental disabilities. Western Highlands will link the individuals and families with services and supports to allow them to live successfully in their communities.

Western Highlands will work in partnership with consumers, providers, and communities to coordinate quality services based on best practices and fiscal soundness, which meet the needs of consumers and their families.

OUR VALUES:

- Respect for consumers and families, their individual needs, rights, and responsibilities;
- Excellence and quality in our provider network and in the services offered;
- Sensitivity to ethnic, racial, and age-related differences;
- Partnership with consumers, families, stakeholders, providers, advocates, community resources, and government to provide the highest quality services;
- Empowerment of each individual and/or family member to achieve the fullest possible control over their own lives, in their own communities;

- Choice of providers throughout the eight county area;
- Trust built through honest and open collaboration among consumers, families, providers, and community organizations.

SECTION I Provider Relations

- Medicaid Provider - www.dhhs.state.nc.us/dma/mp/mpindex.htm
- State Funded Provider- www.westernhighlands.org

Problem Resolution/Disputes and Appeals: If problems arise between the Provider and the Area Authority in the delivery of services, the parties shall attempt whenever possible to resolve these problems informally in a reasonable and timely manner. In the event that informal resolution is not appropriate or is unsuccessful, the process outlined in GS 122C-151.4(pending) shall be followed.

- Link to the North Carolina General Statutes www.ncga.state.nc.us/gascripts/Statutes/Statutes.asp
- Link to the Western Highlands Area Authority Grievance and Appeals procedures www.westernhighlands.org/pr_grievances.htm

Technical Assistance/Training Collaboration:

Area Authorities shall provide timely and reasonable technical assistance regarding new State initiatives, or as the result of monitoring activities as related to the services covered in the Agreement, subject to the State's timeliness and availability of the information necessary to provide the technical assistance. Providers shall give reasonable notice to the Area Authority for any and all requests for technical assistance. Training collaboration shall be done whenever feasible between the Area Authority, or groups of Area Authorities, and Providers, or groups of Providers, in order to effectively and efficiently utilize the resources available to each party. Area Authorities shall give reasonable notice of and completion time frames of Area Authority generated report requests and of changes to or new State reporting requirements, subject to timeliness and availability of necessary information on the requirements from the State.

Both parties recognize the necessity to respond to and comply with State and Federal requirements that may have immediate implementation timeframes.

Providers may request technical assistance and or collaboration on training at any time via phone, fax, or e-mail. The Area Authority will respond by providing technical assistance in good faith to the best of the ability of available staff. The Area Authority shall provide ongoing technical support in the form of monthly or other regularly scheduled provider meetings and notification of requirements via fax and e-mail.

2.18 Training and Technical Assistance. The Area Authority/County Program reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The Area Authority/County Program shall also mandate Provider attendance at selected Clinical Sessions of which the Provider bears the cost, whether Area Authority/County Program sponsored or offered by outside Parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to Area Authority/County Program its application of training information received in the delivery of services and in compliance with the provisions of this Contract.

Medicaid Funded MOA – Article I – 1.6

1.6 Training and Technical Assistance. The Provider must attend all relevant Orientation Sessions as determined by the Area Authority at no cost to the Provider. The Provider shall attend all mandatory trainings as related to business practices at no charge to the Provider as space permits. The Area Authority reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The Area Authority shall also mandate Provider attendance at selected Clinical Sessions of which the Provider bears the cost, whether Area Authority sponsored or offered by outside Parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to Area Authority its application of training information received in the delivery of services and in compliance with the provisions of this Agreement.

Information on provider trainings and technical assistance can be found at:

- Medicaid Provider – DMA website www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider – WHN Website www.westernhighlands.org/pr_training.htm

Who to Contact for Questions

For Provider Training, Support, or to Coordinate Technical Assistance Needs

Provider & Consumer Relations

- Phone: 828-225-2785 1-800-671-6560
- Fax: 828-225-2784
- Contacts: www.westernhighlands.org/contact.htm

For General Questions, Policy Matters, Customer Service related issues; initial contact for MOA's

Provider & Consumer Relations

- Phone: 828-225-2785 1-800-671-6560
- Fax: 828-225-2784
- Contacts: www.westernhighlands.org/contact.htm

For Contract-specific Questions (services, rates, contract status, etc.) and Claims Processing Questions

Claims & Reimbursement

- Phone: 828-225-2785 1-800-671-6560
- Fax: 828-258-1225
- Contacts: www.westernhighlands.org/contact.htm

For Questions related to authorization of State funded services

Services Management

- Phone: 828-225-2785 1-800-671-6560
- Fax: 828-225-2779
- Contacts: www.westernhighlands.org/contact.htm

For Questions related to Accessing Services and Opening Cases with WHN

Access Department

- Phone: 828-225-2785 1-800-671-6560
- Fax: 828-225-2782
- Contacts: www.westernhighlands.org/contact.htm

Notification of Change of Address:

Formal notification of change of address of either party shall be given to the other. Procedures and forms for notifying changes to provider demographic information can found at the below links.

- Medicaid Provider- (USE DMA Forms) www.dhhs.state.nc.us/dma/form
- State Funded Provider- (Use WHN Forms)
www.westernhighlands.org/pr_registration.htm

State Funded Contract – Article 3 – 3.11

3.11 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Both parties shall be responsible for notification to the Division of Facility Services and to Area Authority/County Program of all such changes when required to do so. Each Party shall promptly notify the other in writing regarding any merger, name change, acquisition of

another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Contract.

Medicaid Funded MOA – Article 3 – 3.12

3.12 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Provider shall be responsible for notification to the Division of Facility Services and to Area Authority of all such changes when required to do so. Each Party shall promptly notify the other in writing regarding any merger, name change, acquisition of another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Agreement. Area Authority may terminate this Agreement in its discretion if Provider is acquired, merged or experiences a change in ownership or control.

Section II

Comprehensive List of State and Federal Requirements for The Area Authority and Provider

The document below serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement.

These documents change based on legislative action, change in federal and state policy, and state procedures. There is a mutual responsibility for Providers and Area Authorities to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if an Area Authority has concerns about how a change will be implemented, then the Area Authority shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the Area Authority for information. If a Provider has problems obtaining or understanding the information referenced in this section, please contact the following department/individual at the Area Authority: **Provider & Consumer Relations Director, 828-225-2785, www.westernhighlands.org/contact.htm**.

**Comprehensive List of State and Federal Requirements for
The Area Authority and Provider**

REQUIREMENT	SUGGESTED ACCESS	WEB SITE, IF AVAILABLE
<p>APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) APSM 45-1 (Confidentiality) APSM 45-2 (Service Record Manual) APSM 45-2a (Service Records Resource Manual) APSM 95-2 (Client Rights) APSM 10-3 (Records Retention and Disposition Schedule) APSM 75-1 (Area Programs Budget ProManual) 45 CFR Par & 164 (HIPAA Standards for Privacy and Security of Health Information)</p>	<p>Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294</p>	<p>Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance www.dhhs.state.nc.us/mhddsas/manuals</p>
<p>CAP-MR/DD Manual –(CAP Providers and Core Competencies Training Requirements for MR/MI service providers)</p>	<p>Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294</p>	<p>http://www.dhhs.state.nc.us/mhddsas/developmentaldisabilities/operations/index.htm</p>
<p>Medicaid-Related Documents Medicaid-covered services definitions Medicaid Services Guidelines Medicaid Communiqués</p>	<p>Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294</p>	<p>http://www.dhhs.state.nc.us/mhddsas/medicaid/index.htm</p>
<p style="text-align: center;">-</p>	<p style="text-align: center;">-</p>	<p style="text-align: center;">-</p>
<p style="text-align: center;">Residential Licensure Requirements</p>	<p style="text-align: center;">(919) 855-3750</p>	<p>http://facility-services.state.nc.us/provider.htm</p>
<p style="text-align: center;">Health Care Personnel Registry</p>	<p style="text-align: center;">(919) 733-8500 or (919) 715-0562</p>	<p>http://facility-services.state.nc.us/hcarpage.htm and www.ncnar.org</p>
<p style="text-align: center;">SB 163- Monitoring of Providers</p>		<p>http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm</p>

State Level		
<p style="text-align: center;">General Statutes</p> <p style="text-align: center;">122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985</p> <p>Applicable sections include but are not limited to:</p> <ul style="list-style-type: none"> ▪ 122C-3 Definitions ▪ 122C-4 Use of phrase “client or his legally responsible person ▪ 122C-51 Declaration of Policy on clients rights ▪ 122C-52 Right to confidentiality ▪ 122C-53-56 Exceptions... ▪ 122C-57 Right to treatment and consent to treatment ▪ 122C-58 Civil Rights and civil remedies ▪ 122C-59 Use of Corporal punishment ▪ 122C-60 Use of physical restraints or seclusion ▪ 122C-61 Treatment rights in 24-hour facilities ▪ 122C-62 Additional rights in 24-hour facilities ▪ 122C-63 Assurance for continuity of care for individuals with mental retardation ▪ 122C-64 Human rights Committees ▪ 122C-65 Offenses relating to clients ▪ 122C-66 Protection from abuse and exploitation; reporting ▪ 122C-67 Other rules regarding abuse, exploitation, neglect, no prohibited ▪ 122C-(116,141,142,146) Local Government Entity ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc ▪ 90-21.4 Treatment of Minors ▪ 7A 517, 452-553 Abuse and neglect of Minors ▪ 108A 99-111 Abuse and Neglect of Disabled Adults ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc. 		<p>All of the NC general statutes can be located on-line at the following site. Just type in the statute number you wish to review in the search box that is in this site.</p> <p>www.ncleg.net</p>
DHHS Disaster Preparedness, Response and Recovery Plan		www.dhhs.state.nc.us/mhddsas/disasterpreparedness/index.html
SB 926- Monitoring of Providers		http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm
Performance Agreement(03-04) between DMH and Area programs-Attachment 12-prompt pay		www.dhhs.state.nc.us/mhddsas/performanceagreement
Contract between the Area Authority and the NC division of MH/DD/SAS		http://www.dhhs.state.nc.us/mhddsas

Federal level		
Drug Free Workplace Act of 1988 as revised	Library-Federal Laws	http://www.dol.gov/elaws/drugfree.htm
Section 503 and 504 of the Rehabilitation Act of 1973	Library –Federal Laws	http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eoo
Civil Rights Act of 1964	Library-Federal Laws	www.eeoc.gov http://www.eeoc.gov/policy/vii.html
Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16	Library-Federal Laws	www.dol.gov
Public Law 99-319, May 1986 Protection and Advocacy for Mentally Ill Persons	Library-Federal Laws	http://thomas.loc.gov/bss/d099/d099laws.html Search for 99-320
<ul style="list-style-type: none"> ▪ Title I Protection and Advocacy Systems ▪ Title II ReinStatement of Rights for Mental Health patients 		http://www4.law.cornell.edu/uscode/42/ch114.html
Public Law 100-509 Protection & Advocacy for Mentally Ill Individual Amendments Act of 1988, October 1988	Library-Federal Laws	http://thomas.loc.gov/bss/d100/d100laws.html Search for 100-509 http://www.oxfordhouse.org/fairhouse.html
Public Law 101– 496 Developmental Disabilities Assistance and Bill of Rights Act of 1990	Library-Federal Laws	http://thomas.loc.gov/bss/d101/d101laws.html Search for 101-496
42 CFR Part 2 Confidentiality Regulations 45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information	Library-Federal Laws	Federal Regulations search: http://www.gpoaccess.gov/cfr/index.html
Office of the Inspector General (Exclusions - “Lower-tier Transactions and disbarment”)	Library – Federal Laws	http://oig.hhs.gov/fraud/exclusions.html
Pro-children Act Section 1041-1044 of the Educate America Act of 1994 prohibiting smoking in areas used by children.	Library – Federal Laws	http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html
Americans with Disabilities Act	Library – Federal Laws	http://www.usdoj.gov/crt/ada/adahom1.htm
OTHER		
North Carolina Council of Community MH/DD/SAS Programs		www.nc-council.org
Area Authority/LME -Specific		
Local Business Plan	Contact: 828-225-2800	www.westernhighlands.org
Local Policies and Procedures	Contact: 828-225-2800	www.westernhighlands.org

Section III Authorization Process

For a listing of policies, procedures, and the latest forms to request an authorization for services please use the below appropriate link. It is incumbent upon the provider to regularly check the below links for updates and changes. Inability of the provider to begin using new procedures or forms could result in a delay or denial in an authorization of services.

- Medicaid Provider - www.dhhs.state.nc.us/dma/home.htm
Value Options - www.valueoptions.com/provider/contractspecific/nmedicaid.htm
- State Funded Provider - WHN Website
www.westernhighlands.org/pr_servauthprocedures.htm

Section IV Claims

Area Authority/LME Fee Collection Policy and Minimum fee/sliding scale fee schedule:

- Medicaid Provider - www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider- www.westernhighlands.org/pr_reimbursement.htm

Western Highlands Area Authority has the responsibility and obligation to the residents and consumers of its catchment area to secure all available resources for the provision of mental health, substance abuse, and developmental disability services. To fulfill this obligation, the Area Authority will make every effort to maximize the earning of State funding, including Division of Mental Health (DMHDDSA) and Medicaid (DMA) funds. The Area Authority, in conjunction with its network of qualified providers, will also work to secure other funds that are consistent with this responsibility.

Western Highlands Client Fee Assessment and Collection Practices assures compliance with all Federal and State statutes, rules, regulations and policies of the Medicaid Program, and will adhere to the conditions set out in any Provider Participation Agreement entered into by and between the Area Authority, the Division of Medical Assistance, and the Division of MHDDSA Services. As in accordance with NCGS 122C-146, Western Highlands Area Authority takes the position that it "should make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party payment, and that no individual may be refused services because of an inability to pay."

Standard Charges

The Area Authority will establish: service-specific rates of reimbursement with providers, identify those services for which a standard charge and client fee may be assessed, and will

provide a uniform sliding scale fee schedule, including specific minimum fees assessed for certain services, and conditions under which no charges may be assessed to clients (ex: Medicaid eligibility under current regulation). While the Area Authority will have an established rate of reimbursement to the provider and a minimum fee, the Area Authority will not stipulate the standard charge that a provider may adopt as their fee. This discretionary authority allows the provider to identify a prevailing standard charge and supports the principle of consumer choice promoted in State reform.

Fee Reduction Based on "Ability to Pay"

While expecting that providers will assess and collect fees for services provided from all clients and responsible parties who bear such responsibility, Western Highlands Area Authority allows that if the financial circumstances of the client are such that they cannot pay the standard fee, the charges may be reduced in accord with their ability to pay. This determination must always be in compliance with applicable rules, laws, and policies related to federal and other third party payors.

In no case may an Area Authority provider deny services in an emergency or to a high-priority client based solely on the inability to pay a fee. It is recognized by the Area Authority that many persons needing services may not be able to pay the full cost of such services. Through the Sliding Scale Fee Policy issued by the Area Authority to all Qualified Network Providers, clients may qualify for a reduction of the full amount of charges as payment for services. The Sliding Scale Fee Policy includes requirements that the provider collect from the client or person responsible for the client's bill written proof of their income, number of dependents, and other pertinent financial information, including information on insurance accepted by the Qualified Provider Network, and other third party information, so long as all laws and policies related to applicable federal and other third party payors permit it. The Sliding Scale Fee Policy will also identify clients eligible for the established minimum fee, as well as the discount from the Provider's Standard Fee Charge for services that may be assessed.

A copy of the current Sliding Scale Fee Schedule and Minimum Fees for Services can be found at: www.westernhighlands.org/pr_reimbursement.htm

Procedure for Setting Client Fees

The Area Authority will make available a procedure for determining clients' level of financial responsibility for services with standard fee charges. This procedure will take into account each clients' eligibility for any and all third-party insurance and coverage, income, and number of dependents. Providers will be expected to administer this procedure uniformly, consistent with HIPAA Privacy Act provisions, and with a minimal invasion of Area Authority clients' personal privacy.

The procedure will provide for fully informing Area Authority clients of the provider's policies and procedures regarding the appointment process, fees, payments, collections, handling of over-due accounts, assignment of benefits, third party coverage's and responsibilities, and other charges. Additionally, the Provider will be expected to complete a two part Financial Intake Summary (to be executed at each client's intake interview) and to provide a copy to the client. The original Financial Intake Summary, along with a copy of the documentation required to verify the fee, must be kept on file by the provider.

Financial Re-evaluation of Center Clients

Providers will be required to re-evaluate client financial status every year during the birthday month to determine whether the ability to pay for services has changed. The provider will ask the client whether there have been any changes in the client's income, number of dependents, or eligibility for insurance, etc. that impact the current fee responsibility determination. If there are changes, the provider will complete a new Financial Intake Summary, which will be documented in the client record and a copy of which will also be given to the client. When a former Area Authority client returns for services, the provider staff will conduct a new financial intake. A new and complete financial intake will also be completed when a previously closed case is re-opened.

Through the Provider Monitoring process, the Area Authority will monitor this process as well as the other aspects of the reimbursement system to insure that these policies and procedures are carried out.

Third Party Reimbursement

It will be the standard policy of the Area Authority that Providers be responsible for the pursuit of all third party reimbursement for services provided. In accordance with federal Medicaid and State Division of MHDDSA policy, providers will be required to demonstrate that third party responsibility is satisfied prior to reimbursement of services by the Area Authority. The Area Authority will adopt, within its Reimbursement Rates and the terms of its contractual agreement, provider reimbursement rates, which recognize and encourage the provider's responsibility to fulfill third party responsibility.

Fee Collection Process

Western Highlands Area Authority and its member Qualified Providers will be required to have a consistent system for collection of appropriate fees from clients. Clients who have financial responsibility for services are required to pay for the services being rendered at the time of each visit and for any delinquent payments. The collections system must be able to provide clients notice of when specific services have been paid, the nature of each charge assessed to the client, information on the current balance due, and a means by which clients may receive information concerning the status of their account. The Provider's fee

collections system must also include written guidelines for write-offs to first and third party accounts.

Providers are encouraged to include in their fee collection process appropriate means of communicating fees due to clients and may use appropriate measures to collect fees, including front desk payments, telephone calls, mailed statements, and collection letters/notices. Providers may employ third parties to assist in collection efforts, provided that the provider and all agents acting on its behalf act in compliance with all applicable federal and state collection regulations and practices.

Providers are expected to monitor the payment of fees by their clients and to inquire as to reasons for delinquent payment. If a client is delinquent in paying for services rendered, Providers may establish an alternative payment plan ("Contract"). If the Provider has established an alternative payment plan (ex: Contract), the terms of that plan will be followed. **Providers who determine that a client is not meeting their financial responsibility and who have exhausted all reasonable means of collecting fees, including direct contact with the client and a minimum of two collection letters, may terminate client services, provided that authorization to do so is approved by the Area Authority.** In no event may the Provider suspend or terminate services to clients determined by the Area Authority to be "high priority" and requiring services.

For additional policies, procedures, and communications around reimbursement and claims please view the information posted at: www.westernhighlands.org/pr_reimbursement.htm

Claims Filing Requirements:

- State Funded Provider- www.westernhighlands.org/pr_reimbursement.htm

State Funded Contract – Article 5 – 5.5

5.5 Submission of Invoices. Provider shall submit an invoice to the Area Authority/County Program within sixty (60) days of the date of service or sooner if required by IPRS timely filing deadlines. All invoices submitted by the Provider to Area Authority/County Program after sixty (60) days will be excluded from the timelines governing the prompt pay provisions.

Area Authority Providers should submit all purchase of service claims to the Area Authority electronically. All claims for services provided shall be submitted no later than 60 days past date of service. Payment of these services is subject to the prior authorization of services and compliance with all billing requirements.

All forms and procedures for the appropriate documentation of claims for services can be found at the above Western Highlands Area Authority web page.

All claims for services should be sent electronically, delivered via US Mail, other commercial courier, or in person to the Reimbursement & Claims Unit of the Western Highlands Area Authority Business Office, 356 Biltmore Avenue, Asheville, NC 28801.

Electronic Billing Options: Providers may bill either or both HIPPA complaint 837-Professional or the Western Highlands web-portal, Direct Data Entry (DDE).

Electronic Billing and connectivity requirements are available at www.westernhighlands.org/pr_reimbursement.htm.

Electronic Connectivity Requirements:

Internet connection:

- Recommended: Broadband Internet access (Examples: DSL, cable, Satellite, Skyrunner wireless, etc...)

E-mail access

- Providers are required to keep an active E-mail account in order to receive Communications, Notifications, and letters of authorization from Western Highlands Area Authority.
- If there are any changes in E-mail address' it is incumbent upon the provider to notify the Provider and Consumer Relations department of Western Highlands Area Authority (www.westernhighlands.org/contact.htm) to prevent loss of Communications or letters of authorization.

Payment Schedules:

All Western Highlands Area Authority payment and Checkwrite Schedules can be found at the below Western Highlands website.

- Medicaid Provider DMA website www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider- WHN website www.westernhighlands.org/pr_reimbursement.htm

Claims Adjudication:

- State Funded Provider- www.westernhighlands.org/pr_reimbursement.htm

State Funded Contract – Article V – 5.0

5.0 Claims/Invoice Review. Area Authority/County Program shall review claims within eighteen (18)calendar business days after receipt and shall notify Provider within that

timeframe if the claims/invoice or portions of the claims/invoice are denied or if further information is necessary. Area Authority/County Program shall pay approved or undisputed portions of the claims/invoice for services performed by Provider within thirty (30) calendar days after approval. Such payment constitutes full and final payment of approved claims/invoice.

Prompt Pay:

- See attached, Attachment 16-Prompt Pay Provision
- State Funded Provider- www.westernhighlands.org/pr_reimbursement.htm

Section V
Provider Documentation Submission Requirements

- Medicaid Provider - www.dhhs.state.nc.us/dma/provenroll.htm
- State Funded Provider– AA/CP policies/procedures

Section VI
Quality Improvement and Performance Monitoring

Provider Monitoring:

Providers shall be responsible for full participation in the Area Authority Provider 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.

As part of the Provider Monitoring process the Area Authority will conduct regularly scheduled monitoring reviews of providers. The Area Authority will provide timely notification of scheduled reviews to providers. Prior to review providers will comply with all requests for information required to complete the review. After completion of the monitoring review the Area Authority will provide a written report to the provider documenting areas of strength and

areas that are deficient and requiring a Plan of Corrective Action to the Area Authority. The Provider shall cooperate and comply with all requests for Plans of Corrective Action; and unless appealed, to promptly correct all problems or deficiencies, or take recommended action, as may be determined by such Committee to be necessary or appropriate.

Western Highlands Area Authority reserves the right to conduct unannounced Provider Monitoring reviews without notification to providers.

Procedures, Communications, and forms related to Provider Monitoring can be found at the below Western Highlands website link.

- WHN website- www.westernhighlands.org/pr_performance.htm
- See attached SB163

Client Rights Reporting:

State Funded Contract – Article II – 2.3

2.3 Rights of Individuals. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of Area Authority/County Program. The Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of Area Authority/County Program.

The Provider must meet the minimum requirements of the Division MH/DD/SA Client Right's rules as referenced in Section 2.3 of the Agreement and any additional requirements specified in the Area Authorities formal Client Rights Policy (see www.westernhighlands.org/clientrights.htm), if more restrictive than Division requirements.

Providers shall maintain a Client Rights Committee and forward all minutes of the meetings to the Area Authority on a quarterly basis. If agencies intend to collaborate with other agencies, and form a multi-agency Client Rights Committee, they are required to submit in writing to the Area Authority all agencies that form the collaboration and any changes that may occur in the collaboration for the extent of this agreement. Technical assistance to the Provider in the duties, maintenance, and requirements of Client Rights Committees is available from the Area Authority upon request.

Data from Report Summaries are compiled and presented to the Area Authority Client Rights Committee. The Provider shall cooperate with the Area Authority Client Rights Committee in all reviews, investigations, or grievances, and promptly produce all records and information as may be requested; and unless appealed, to promptly correct all problems or deficiencies, or take recommended action, as may be determined by such Committee to be necessary or appropriate to protect client rights.

- www.dhhs.state.nc.us/mhddsas/manuals/forms/dhhs-incident11-18-04

- www.westernhighlands.org/clientrights.htm

Incident Reporting: *All incidents pertaining to Area Authority clients shall be reported to the Area authority and NC DHHS as required in APSM 95-2(Client rights) and APSM 30-1 (Quality Assurance/Improvement), and 10A NCAC 27G.0600. [NOTE: there's also a form (DHHS Incident and Death Form) and manual for incident reporting at the below links.]*

All Incidents must be reported to the appropriate Western Highlands program liaison within 72 hours of their occurrence. Statewide Critical Incident Reporting Forms and instructions can be found at the below links. Technical assistance to the Provider in the duties, maintenance, and requirements of Incident Reporting are available from the Area Authority upon request.

Data from Incident Reports are compiled and presented to the Area Authority Critical Incident Review Committee. The Provider shall cooperate with the Area Authority Critical Incident Review Committee in all reviews and investigations, and promptly produce all records and information as may be requested; and unless appealed, to promptly correct all problems or deficiencies, or take recommended action, as may be determined by such Committee to be necessary or appropriate.

- <http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm>
- www.westernhighlands.org/pr_incident.htm

Person-Centered Planning:

All consumers of the Area Authority receiving Enhanced Benefits will have an individualized Person-Centered and Crisis Plan. Providers should use the designated forms issued by the Division of MH/DD/SAS. Forms and instructions for Person-Centered and Crisis planning can be found at the two below links. All providers should meet the mandatory Person-Centered Planning training requirement as per service definition.

Technical assistance to the Provider in the Person-Centered/Crisis Planning process is available from the Area Authority upon request.

- Division of MH/DD/SAS website- www.dhhs.state.nc.us/mhddsas/
- WHN website- www.westernhighlands.org/pr_crisisplan.htm

Clinical Outcome Measures:

Clinical outcome measures
Satisfaction surveys

As noted in Section 2.6 of the Agreement, Providers must conduct their own quality assurance and utilization review programs (that have been approved during a compliance

verification/accreditation/licensure review) and provide evidence of such to the Area Authority upon request.

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 area authority in any quarter of completion.

Providers shall meet compliance standards with established protocols for each eligible consumer (NC-TOPPS, COI). As applicable to the service population, providers shall also participate in the annual Core Indicators and Consumer Satisfaction Surveys.

State Funded Contract – Article II – 2.6

2.6 Quality Management. Provider of benefits shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of assessment of quality of care and best practices, effectiveness and satisfaction with services to the Area Authority/County Program upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and implement evidence-based practices as defined and adopted by the Division of MH/DD/SA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process.

NC-TOPPS:

- www.dhhs.state.nc.us/mhddsas/announce/index.htm
- <http://nctopps.ncdmh.net/>

Responsibility for completing the NC-TOPPS assessment lies with the provider agency that is considered the consumer's "clinical home." The "clinical home" is the provider agency that is responsible for completing the consumer's Person Centered Plan (PCP). If in question the Area Authority will provide guidance on determining which provider agency is the "clinical home." The Qualified Professional (QP) completing the PCP is responsible for insuring that NC-TOPPS Assessments are completed. NC-TOPPS Assessments are used to document a consumer's episode of treatment at the beginning of treatment, during treatment and at the end of treatment. The QP must complete an Initial, Update (3-Month, 6-Month, 12-Month, and every 6 months thereafter (18, 24, 30, 36 months, etc.)) and a Transfer or Discharge, when appropriate, for designated substance abuse and mental health consumers. NC-TOPPS is to be administered with the consumer as a regular part of developing and updating a consumer's PCP and providing treatment and services. A copy of all completed NC-TOPPS Assessments is required in the consumer's service record.

Consumers with Multiple Providers

Only one Initial Assessment and appropriate Updates and Transfer or Discharge Assessments are needed per consumer. NC-TOPPS Assessments should capture all services received during a consumer's episode of treatment. This will require communication and coordination among all

involved providers. If the consumer is being treated by multiple providers, the QP from the “clinical home” who is responsible for developing, assessing and updating a consumer’s PCP is also responsible for the completion of NC-TOPPS Assessments. If in question the Area Authority can provide guidance on determining which provider agency is the consumer’s “clinical home.”

Substance Abuse and Mental Health Consumer Requirements

- NC-TOPPS Assessments are required for 100 % of consumers who have
 - Completed the screening and intake process
 - Formally been admitted for treatment by having received an open record with a unique consumer record number through the LME
 - A diagnosis from the Diagnostic and Statistical Manual (DSM) IV diagnosis or International Classification of Disease (ICD) 9 code, or latest version of either
 - Been enrolled in a target population by an assigned LME and receiving services, (including medication management), except for the following noted exclusions

Substance Abuse and Mental Health Consumer Exclusions

- Consumers receiving crisis services only or detoxification services only
- Consumers receiving substance abuse prevention services only (Integrated Payment and Reporting System (IPRS) Child Substance Abuse Selective Prevention (CSSP) and/or Child Substance Abuse Indicated Prevention (CSIP) target populations)
- Consumers receiving inpatient psychiatric hospital services only
- Consumers in an IPRS Transitional Non-Covered population only
- Consumers who do not have a diagnosis from the DSM-IV or ICD 9 code, or latest version of either
- Consumers receiving Medicaid funded Basic Benefits only (8 outpatient therapy sessions for adults, 26 outpatient therapy sessions for children)

Consumers who are members of both DD and MH or SA target populations require a NC-TOPPS only when the services are predominantly either MH or SA. Otherwise, a COI is required for this population when the consumer falls into the COI sample. Consumers in the Mental Retardation/Mental Illness (MRMI) target population fall under the COI requirement.

Section VII

-State Funded Providers-Area Authority Specific Policies/Forms/Local Governance Requirements

Regular updates to policies and standard operating procedures will be distributed to providers via e-mail through WHN Communication Bulletins. These bulletins can be found at the below link.

WHN Website- http://www.westernhighlands.org/pr_commbulletins.htm

Section VIII Glossary of Terms

(Division's-any area Authority/AREA AUTHORITY additional terms should be added)

Definitions included in this section are primarily for clarification of terms used in the body of this Agreement, its attachments and manual. However many of these definitions are also used in existing state and Area Authority documents and are included here to be helpful but are not to be considered comprehensive. Where similar definitions apply to multiple terms, the terms are grouped. Broad categories are defined with specific elements detailed as a part of the entire definition.

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION – Certification by an external entity that an organization has met a set of standards.

ACT-Assertive Community Treatment

ADULT- means a person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies.

ADMINISTRATIVE SERVICES- means the services other than the direct provision of MH/DD/SA services (including case management) to eligible or enrolled persons, necessary to manage the MH/DD/SA system, including but not limited to: provider relations and contracting, provider billing accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representative of the Contractor at Administrative hearings concerning the Contractor's decisions and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality management.

ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field.

AOC - Administrative Office of the Courts.

APPEAL- means a formal request for review of a decision made by the Contractor or a subcontracted provider related to eligibility for covered services or the appropriateness of treatment services provided.

APPEALS PANEL - The State MH/DD/SA appeals panel established under NC. G.S.

371.

ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.

AUTHORIZATION - The process by which Utilization Management agrees to a medically necessary specific service or plan of care based upon best practice. The granted request of a provider is assigned a number for tracking and linked to the subsequent claim that will be made for reimbursement. *PRE-AUTHORIZATION/PRIOR AUTHORIZATION* is the process of approving use of certain resources in advance rather than after the service has been requested. Approval for admission to hospitals in an emergent situation is one example. *RE-AUTHORIZATION* is the process of submitting a request for services for a consumer who has already received authorized services. The request shall specify the scope, amount and duration of service requested and shall indicate the consumer's progress toward outcomes, the use of natural and community supports, and how the requested services will support the outcome the individual is seeking. *RETROSPECTIVE AUTHORIZATION* is authorization to provide services after the services have been delivered.

BASIC SERVICES – Mental health, developmental disability or substance abuse services that are available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.

BENEFIT PACKAGE OR PLAN – An array of treatments, services and/or supports intended to meet the needs of target or priority populations. *BENEFIT LIMITATIONS* are any provision, other than an exclusion, which restricts coverage, regardless of medical necessity. *Covered Benefits* medically necessary services that are specifically provided for under the provisions of Evidence of Coverage. A covered benefit shall always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered. **BEST PRACTICE (S)** – Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, *EVIDENCE-BASED*, or *RESEARCH-BASED* may also be used.

BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. Also referred to as *CATEGORICAL FUNDING*.

CARE COORDINATION – The methods utilized to notify other providers of significant events in the course of care and to enable multiple providers to give integrated care to an individual. Professionals with a broad knowledge of the resources, services and programs supported by the public MH/DD/SA system and the community at-large advocate for access and link individuals to entitlements and services. It is an administrative Service Management Function performed by the Contractor for individuals not enrolled or not meeting target population definitions.

CARF - Council on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the State served by a specific Contractor. The *GEOGRAPHIC AREA* can be a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide covered services to eligible residents of their area.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

CERTIFICATION – A Statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. The Contractor or the NC Council may be the certifying agency for subcontracted Providers.

CFAC – Each LME has a Consumer Family Advisory Committee which is comprised of consumers and family members representing all disability groups. CFACs meet on a regular basis in their communities to support and communicate their concerns and provide advice and comment on all state and local plans.

CHILD-means an eligible person who is under the age of 18, unless the term is given a different definition by statute, rule or policies.

CLAIMS MANAGEMENT – The process of receiving, reviewing, adjudicating, INVESTIGATING, paying, and otherwise processing service claims submitted by network and facility providers. *CLAIM* – An itemized Statement of services, performed by a provider network member or facility, which is submitted for payment. *CLEAN CLAIM*- means a claim that successfully passes all adjudication edits. *CLIENT* - An individual who is admitted to or receiving public services. “Client” includes the client’s personal representative or designee and the terms *CONSUMER*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CLIENT OUTCOMES INVENTORY (COI) – DMH/DD/SAS measurement system for assessing treatment/services outcomes of mental health and substance abuse service consumers.

CLIENT DATA WAREHOUSE - The DHHS’s source of information to monitor program, clinical and demographic information on the clients served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.

CLINICAL PRACTICE GUIDELINES – Utilization and quality management mechanisms designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The guidelines or *TREATMENT PROTOCOLS* are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups. NC has adopted protocols for MH and DD. NC uses ASAM Guidelines for substance abuse.

COA -Council on Accreditation

CO-MORBID CONDITION- CO-OCCURRING DISORDERS, DUAL DIAGNOSIS –

Terms that reflect the presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions, etc and require specialized approaches.

COMPLAINT – A report of dissatisfaction with some aspect of the public MH/DD/SA system. The term *DISPUTE* is used to indicate a specific complaint about a service or a provider that requires attention and joint resolution.

CONFLICT OF INTEREST – A situation where self interest could negatively impact the best interests of the person being served or the system.

CONSENSUS - Majority opinion regarding a group decision. It is not the same as total agreement.

CONSUMER- An individual who is admitted to or receiving public services. “Consumer” includes the consumer’s personal representative or designee and the terms *CLIENT*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CONSUMER/FAMILY ADVISORY COMMITTEE – A Board appointed group of persons receiving services, families of persons receiving services, advocates and other stakeholders that participate in meaningful decision making relative to the local program. The group shall meet at least monthly in a public forum to review data, practices, policies and plans of the Contractor and make recommendations to the Board from the consumer/family perspective.

CONTRACT- A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is time limited. A contract is defined as a document that governs the behavior of a willing buyer and a willing provider. In this case the Contract is the 2004 Performance Agreement between the Department and the LME.

CONTRACTOR - an organization or entity agreeing by signature to provide the goods and services in conformance with the Stated contract requirements, NC statute and rules and federal law and regulations.

CONTRACT YEAR-a period from July 1 of a calendar year through and including June 30 of the following year.

COPAYMENT- The portion of the cost of services which the enrolled person pays directly to the Contractor or the subcontracted providers at the time-covered services are rendered.

CORE SERVICES – *BASIC SERVICES* such as screening, assessment, crisis or emergency services available to any person who needs them whether or not they are a member of a target or priority population. The term also includes universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders. **CORPORATE COMPLIANCE** – The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

CREDENTIALING – The process of approving providers for membership in a network to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

CRISIS – Response to internal or external stressors and stressful life events that may seriously interfere with compromise a person’s ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself. *CRISIS RESPONSE* is the immediate action to assess for acute MH/DD/SA service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate services. These services are available 24 hours per day, 365 days per year.

These services may be referred to as *EMERGENCY* services as well. NC requires a *CRISIS PLAN* for consumers to promote recovery and to lessen the trauma of emergency events. **CULTURAL COMPETENCE/PROFICIENCY** –A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing that we accept and value others even when we may disagree with them.

CUSTOMER – Customers may be *ULTIMATE CUSTOMERS* who are the intended and actual recipients of the services provided by the public system, *INTERNAL CUSTOMERS* are those individuals internal to the system who rely on each other to provide the service to the ultimate customer; and *EXTERNAL CUSTOMERS* are those groups and individuals outside the system that have a take in the outcomes and products produced by the system. The concept is critical to proper implementation of

DD - Developmental Disability

DEFAULT – The breach of conditions agreed to in this Contract and/or failure to perform based upon defined terms and conditions the scope of work specified in the Contract.

DE-INSTITUTIONALIZATION – Release of people from institutions to care, treatment and supports in local communities. De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in *OLMSTEAD V. LC* has given new momentum to development of community based services for individuals who have remained in State hospitals and mental retardation centers because community services were not available. This movement is often referenced as movement to least restrictive care or to lower levels of care where safety and community integration are balanced and supported through the community system of services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees State government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DHHS- Department of Health and Human Services.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders.

DISASTER – A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress, and economic loss. Disasters result in situations that call for a coordinated, multi-agency response. A disaster calls for a response and resources that usually exceed local capabilities.

DIVERSION – Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a State hospital. The term is also used when preventing arrest or imprisonment by providing services that restore functioning and avoid detention. In North Carolina diversion programs are in place in response to SB859 that prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North

Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DJJDP - Department Of Juvenile Justice and Delinquency Prevention.

DOMAINS - Major areas of concern to the NC public MH/DD/SA system and its mission, goals, and strategies and for which indicators and measures are developed to examine outcomes of service in the lives of people served.

DPI -Department of Public Instruction

DSS - Department of Social Services

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

(EPSDT) – Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. Education and training are also activities or programs delivered to staff to ensure that service providers are competent to provide services identified as best practices.

ELIGIBILITY – Determination of the service and/or benefit package an individual may be entitled to or determination of a class membership that allows entry to certain services and supports. The determination that individuals meet prescribed criteria for a particular program, set of services or benefits.

EARLY INTERVENTION - The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.

EMERGENCY- Means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply:

- o The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
- o The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- o The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental

disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

ENROLLED – Individuals are admitted for service and have been provided at least one service and assigned a unique identifying number.

FAIR HEARING RIGHTS – Advance and Adequate Notice - The Contractor notice in accordance with DHHS policy and procedure using prescribed forms when denying, reducing, suspending or terminating covered services that require prior authorization. The Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by State and federal law and regulations. **FEE FOR SERVICE** – A method of payment for health care. A payer pays the Contractor or a service provider for each reimbursable treatment, upon submission of a valid claim, and according to agreed upon business rules. The *FEE SCHEDULE* is a list of reimbursable services and the rate paid for each service provided.

FEMA - Federal Emergency Management Agency

FORENSIC – Term used to describe a person with mental illness, developmental disability or substance abuse who is involved in the criminal justice system. This includes persons found Not Guilty by Reason of Insanity (NGRI), those who are Incompetent to Stand Trial, or who are in jails or prisons or referred to the mental health system by criminal courts for evaluation and treatment.

FORMULARY – A list of drugs that are considered preferred therapy for a given condition and cost effective and are to be used by providers in prescribing medications. **FUNCTIONAL OUTCOMES** - The extent to which individuals receiving services and supports reach their goals. These outcomes generate from *DOMAINS* as defined earlier related to desirable life developments that all people wish to achieve, such as safe and affordable housing, employment or a means of support, meaningful relationships, participation in the life of the community, etc.

GAPCD - Governor's Advisory Council for Persons with Disabilities

GENERAL FUND – State funds used by the General Assembly for public programs and initiatives.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area. The Contract standard is 30 minutes/30 miles.

GRIEVANCES – A formal complaint by a service recipient that shall be resolved in a specified manner detailed in this Contract.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, State, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) –Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper-based, and mandates “best effort” compliance.

HIPAA - Health Insurance Portability and Accountability Act

HUD - Housing and Urban Development

HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to rights violations guaranteed by law and under this contract.

INCURRED BUT NOT REPORTED (IBNR)- means liability for services rendered for which claims have not been received. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. Failure to account for these potential claims could lead to inaccurate financial estimates.

INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.

IPRS-Integrated Payment Reporting System

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) –

Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LBP - Local Business Plan

LEAST RESTRICTIVE CARE – The service that can be provided in the most normative setting while insuring the safety and well being of the individual.

LENGTH OF STAY (LOS) – The amount of time that a person remains in a service program, including hospitals, expressed in days.

LEVEL OF CARE (LOC)- A structured system for evaluating acuity and *INTENSITY OF NEED* against the amount, duration and scope of service required by a consumer. For substance abuse programs, As used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.

LICENSURE – A State or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.

LME - Local Management Entity

LOCAL BUSINESS PLAN – In the reformed MH/DD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCAL MANAGING ENTITY (LME) - The local administrative agency that plans, develops, implements and monitors services within a specified geographic area according to the terms of this Contract including the development of a full range of services and/or supports for both insured and uninsured individuals.

LOCAL QUALITY MANAGEMENT COMMITTEE – A cross system group of stakeholders including the LME, providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

MANAGEMENT REPORTS – Collections of data that are benchmarked to enable the agency to compare performance against standards and to seek continuous improvement. The reports should be comprehensive incorporating timeliness, utilization and penetration rates, customer satisfaction, functional outcomes and compliance with various standards and terms inherent in this Contract.

MEDICAID – A jointly Funded federal and State program that provides medical expense coverage to low-income individuals, certain elderly people and people with disabilities. The Federal government requires that the State/local government match the federal government funds. In North Carolina, this is approximately 60% federal/40% State/local match. People qualifying for Medicaid are “entitled” to supports and services based upon a State Medicaid Plan that is approved by the Federal Government. That Plan describes the services and benefits the individual is entitled to receive and the conditions of service provision.

MEDICAL DIRECTOR – A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system under the terms of this Contract.

MEDICAL NECESSITY - Criteria established to ensure that treatment is essential and appropriate for the condition or disorder for which the treatment is provided. The criteria reference the scope, amount and duration of service appropriate for levels of acuity and rehabilitative care.

MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with long term disabilities.

MEMBER HANDBOOK – A document developed and disseminated by the Contractor according to parameters established in this Contract to inform potential eligibles, eligibles, and enrolled persons of their rights, responsibilities and treatment coverages.

MEMORANDUM OF AGREEMENT (MOA) or MEMORANDUM OF UNDERSTANDING (MOU) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.

MH - Mental Health

MMIS - Medicaid Management Information System.

MST - Multi-Systemic Therapy

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)-A non-profit organization created to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector.

NATIONAL PRACTITIONER DATA BANK (NPDB) – A database maintained by the federal government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions that have been taken.

NATURAL AND COMMUNITY SUPPORTS - Places, things and, particularly, people who are part of our interdependent community lives and whose relationships are reciprocal in nature.

NCQA - National Council for Quality Assurance

NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.

NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OPERATIONAL AND FINANCIAL REVIEW-means the review of the Contractor conducted by DMH/DD/SAS to assess compliance with contract requirements. **OUTREACH** - Programs and activities to identify and encourage enrollment of individuals in need of MH/DD/SA services and/or to encourage people who have left service prematurely to return.

PATIENT PLACEMENT CRITERIA (PPC) - Standards of, or guidelines for, alcohol, tobacco and other drug (ATOD) abuse treatment that describe specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge / transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on ATOD diagnosis and other specific areas of patient assessment.

PCP - Person Centered Plan

PCPM – Per Citizen Per Month. The basis on which the Contractor is paid for administrative functions under the terms of some contracts.

PEER REVIEW – The analysis of clinical care by a group of that clinician’s professional colleagues. The provider’s care is generally compared to applicable standards of care, and the group’s analysis is used as a learning tool for the members of the group. **PENETRATION** – The extent to which the system serves those individuals expected to have a specific medical condition, in this case persons with developmental disabilities, persons with mental illnesses and persons with substance abuse disorders. **PERFORMANCE INDICATORS** - Measurable evidence of the results of activities related to particular areas of concern as indicated in this Contract. The measures are quantitative indicators of the quality of care provided that consumers, payers, regulators and others could use to compare the care or provider to other care or providers.

PERFORMANCE STANDARDS- Benchmarks an agency or provider is expected to meet. The standards define regulatory expectations and in meeting them the agency or provider may meet a required level for “certification” or “accreditation”.

PERSON-CENTERED PLANNING - A process focused on learning about an individual’s whole life, not just issues related to the person’s disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited and identifying and gaining access to supports from a variety of community resources prior to utilizing the community MHO/DD/SA system to assist the person in pursuit of the life he/she wants. Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and the services being requested from the public system to achieve the consumer’s desired outcomes. The plan is used as the basis for requesting an authorization for services. **PHYSICAL**

DEPENDENCE - A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently require the drug in order to function. If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.

PLAN OF CORRECTION – A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcomes.

PP - Primary Provider

PREVALENCE – The estimated degree of incidence of a condition in a given population.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal Prevention programs reach

the general population; Selective Prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; Indicated Prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PSR - Psychosocial Rehabilitation

RESPONSIBLE CLINICIAN - An assigned professional deemed competent and credentialed by the Contractor to serve as a fixed point of accountability for the consumer's PCP, monitoring and outreach.

PRIMARY CARE- (a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians—often referred to as primary care practitioners. (b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary. **PRIMARY SOURCE VERIFICATION** – A process through which an organization validates credentialing information from the organization that originally issued the credential to the practitioner.

PRINCIPLE DIAGNOSIS-The medical condition that is ultimately determined to have caused the consumer to seek care. The principal diagnosis is used to assign every consumer to a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PRIVILEGING – Process for determining, usually through training and supervision that an individual provider has the necessary skills and knowledge to offer designated services and can provide them without supervision.

PROMPT SERVICES - Services provided when needed. For target or priority populations, routine appointments within 14 days, initial hospital discharge visits within 3 days, urgent visits within 2 days, emergent visits immediately and no later than 24 hours **qualify as prompt**.

PROVIDER – In this Contract, a person or an agency that provides MH/DD/SA services, treatment, and supports under a subcontract to the LME.

OPERATIONS MANUAL – A document attached to a subcontract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.

PROVIDER PROFILING – The process of compiling data on individual provider patterns of practice and comparing those data with expected patterns based on national or local statistical norms. The data may include medication prescribed, hospital length of stay, size of caseload, and other services. Some data may be compiled for use by consumers in choosing preferred providers based on performance indicators.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, and commissions and boards responsible for the provision of publicly Funded services to consumers.

QA - Quality Assurance

QI - Quality Improvement

QIC - Quality Improvement Committee

QM - Quality Management

QPN - Qualified Provider Network

QUALIFIED PROVIDER NETWORK – The group of subcontractors subcontracted by a Contractor to provide supports and

services to persons for whom the Contractor authorizes care.

QUALITY MANAGEMENT (QM)- The framework for assessing and improving services and supports, operations, and financial

performance. Processes include: **QUALITY ASSURANCE**, and **QUALITY IMPROVEMENT**.

QUALITYIMPROVEMENT (QI) is a

process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers and administrative functions. **QUALITY ASSURANCE (QA)** involves periodic monitoring of compliance with standards.

RECOVERING STAFF - Counselors with and without educational degrees working in the substance abuse treatment fields who are in recovery.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

REGISTER – The process of gathering initial data and entering an individual into the service system.

REVENUES – Money earned through reimbursements paid for covered services or other local sources, grants, etc.

SA - Substance Abuse

SAPT - Substance Abuse Prevention and Treatment

STATE-means the State of North Carolina.

STATE PLAN- Annual (each fiscal year) updated comprehensive MH/DD/SAS systems reform plan derived from the systems reform statute and titled "Blueprint for Change".

STATE PLAN (MEDICAID)- The written agreements between the State of NC and CMS which describe how the NC DMH/DD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.

SCREENING/TRIAGE – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for services based on eligibility criteria and acuity level. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SENTINEL EVENT – CRITICAL INCIDENT, UNUSUAL INCIDENT, ETC. A sentinel event may include any type of incident that is clinically undesirable and avoidable. Sentinel events signal episodes of reduced quality of care. Many organizations monitor medication errors, review of deaths, accidents, evacuation drill responses, rights violations, medical emergencies, use of restraint or seclusion, behavior management etc. The purpose of sentinel event monitoring is to discover root causes and implement a continuous improvement process to prevent further events. **SEVERELY EMOTIONALLY DISTURBED (SED)** – A designation for people less than 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services. **SEVERELY MENTALLY ILL (SMI)** – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of

living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people with a mental illness or disorder so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities.

SERVICE MANAGEMENT – An administrative function that includes Utilization Management and Care Coordination under this Contract. The service is carried out by experienced professionals with broad knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of State facilities' bed days, making sure that networks create consumer choice in service providers.

SPECIALIST REVIEW – A consultation or second opinion rendered by a member of the UM staff when an authorization request falls outside the defined criteria for service selection, amount or duration.

STANDARD OF CARE – A diagnostic and/or treatment consensus that a clinician should follow when providing care based upon the discipline's peer group organization, such as the APA or NASW.

STATE MENTAL HEALTH AUTHORITY – The single State agency designated by each State’s governor to be responsible for the administration of publicly Funded mental health programs in the State. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES PLAN – Plan for Mental Health, Developmental Disabilities and Substance Abuse Services in North Carolina. This Statewide plan forms the basis and framework for MH/DD/SA services provided across the State. **STATE OR LOCAL CONSUMER ADVOCATE** - The individual carrying out the duties of the State Local Consumer Advocacy Program Office **SUBSTANCE ABUSE** – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL

GOVERNMENT (SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) -A federal program to provide funds to States to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1 year period.

SUBCONTRACT-means any contract between the Contractor (Contractor) and a third party for the performance of all or a specified part of this Contract. The *SUBCONTRACTOR* means any third party engaged by the Contractor, in a manner conforming to the se contract requirements for the provision of all or a specified part of covered services under this Contract.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires States to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from States that fail to comply with the SYNAR Amendment.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available within the system; populations as identified in federal block grant language. *NON-TARGET POPULATION* are those individuals with

less severe disorders that can be adequately and most cost effectively treated by the private sector, primary physicians or by using generic community resources.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

UM - Utilization Management

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM)- is a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. The administration of services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided. This function is carried out by professionals qualified in disciplines related to the care being authorized and requires their use of tools such as service definitions, level of care criteria, etc.

UTILIZATION-is the use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons per year, or the number of services provided per 1,000 persons by a system of care annually.

UTILIZATION REVIEW (UR)- is an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. The examination of documents and records to assure that services that were authorized were in fact provided in the right amount, duration and scope, within the time frames allotted; and that consumers benefited from the service. The review also

examines whether the actual request for authorization was valid in its assessment of the consumer and the intensity of need. There are a variety of types of reviews that may occur concurrent with the care being provided, retrospectively or in some cases prospectively if there are questions about the authorization requested.

Attachment 16 (Fiscal Management 3)

Prompt Pay Provision

Definition:

As used in this section, “provider” means any qualified public, or private, provider, agency, institution, or resource that contracts with the Area Program for the provision of services pursuant to G.S. 122C-141(a).

Invoice Processing Period Requirements:

Within eighteen (18) calendar days after the Area Program receives an invoice from a provider, the Area Program shall either: (a) approve payment of the invoice, (b) deny payment of the invoice, or (c) determine that additional information is required for making an approval or denial. The foregoing requirement is further specified in the following bullets:

- . • If the Area Program approves payment of an invoice, the Area Program shall pay the invoice within thirty (30) calendar days after making the approval.
- . • If the Area Program denies payment of an invoice, the Area Program shall return the invoice to the provider and include notice specifying the full and complete good faith reasons for the denial within eighteen (18) calendar days after the Area Program received the invoice. The Area Program will be deemed to have complied with this requirement if, on or before the eighteenth calendar day, the Area Program electronically transmits the invoice and notice to the provider, places the invoice and notice in the U.S. mail, first class postage prepaid, properly addressed to the provider, or makes actual delivery of the invoice and notice to the provider.
- . • If the Area Program determines that additional information is required for making the approval or denial of an invoice, the Area Program shall provide the provider with notice of the same. The notice shall contain the specific good-faith reasons why the invoice has not been paid and furnish a complete itemization, or description, of all of the information needed by the Area Program to complete the processing of the invoice. The Area Program shall provide such notice to the provider within eighteen (18) calendar days after the Area Program receives the invoice. The Area Program will be deemed to have complied with this requirement if, on or before the eighteenth calendar day, the Area Program electronically transmits such notice to the provider, places such notice in the U.S. mail, first-class postage prepaid, properly addressed to the provider, or makes actual delivery of such notice to provider. Upon the Area Program’s receipt of the additional information from the provider, the Area Program shall process the invoice within the time periods stated above for approving, denying, and paying invoices.
- . • The Area Program is not limited to approving an invoice in full, denying

an invoice in full, or requesting additional information for an entire invoice. Rather, as appropriate, the Area Program may approve an invoice in part, deny an invoice in part, and/or request additional information for only a part of the invoice, as long as the Area Program either approves, denies, or requests additional information for each part of the invoice within the required eighteen (18) calendar day period. If the Area Program partially approves, denies, or requests additional information for an invoice, the Area Program shall take the appropriate further actions on the invoice within the applicable time periods specified above. For instance, if an invoice is denied in part and approved in part, the Area Program shall pay the approved portion of the invoice within thirty (30) calendar days after the approval and shall send the notice of denial for the denied portion of the invoice within eighteen (18) calendar days after the Area Program's receipt of the invoice.

- The Area Program is presumed to have received a mailed invoice five business days after the invoice has been placed in the United States mail, first-class postage prepaid, properly addressed to the Area Program, or an invoice transmitted electronically, or by facsimile transmission, to the Area Program, or a designated clearinghouse, on the day the invoice is transmitted.

- All references to the term "invoice" in this Section, IV.A.3., "Prompt Pay Provision" shall include invoices for Medicaid services and invoices for non-Medicaid services, except for the references to "invoice" in the provision below captioned, "Submission of Non-Medicaid Invoices to Area Program," which shall include only invoice for non-Medicaid services.

- In calculating any period of time prescribed by this section, IV.A.3. "Prompt Pay Provision," the day of an act, or event, after which a designated period of time begins to run, is not to be included. For instance, in calculating the eighteen (18) calendar days after an Area Program receives an invoice, the day the Area Program receives the invoice is not included or counted, and the first of the eighteen (18) calendar days is the calendar day that follows the day on which the invoice was received.

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North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse
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Funds Availability Provision:

The payment of funds by the Division to the Area Program, as specified by this Agreement, is conditioned upon the appropriation, allocation, and availability of the funds to the Division for this purpose. To this end, if it appears that the payments from the Division to Area Programs will be disrupted due to a statewide reduction in funding, the Division Director shall provide providers and Area Programs with prior notice of the reduction. This notification shall give direction to Area Programs about the appropriate course of action regarding payments to providers. In addition, in instances where the Area Program submits evidence to the Division that reasonably demonstrates that the Area Program's late payment of invoices is the direct result of errors or delays by the State, or its contract vendors, the Area Program shall be exempt from the time periods imposed by this section for approving and paying such invoices. In such circumstances,

the Area Program shall approve and pay the invoices within a time period that is reasonable under the circumstances. If, for any reason, the Area Program anticipates that it will be unable to make payment on an individual invoice within the time periods required by this section, and the Area Program and provider are unable to reach a resolution, the Area Program

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Services

must obtain the prior approval of the Division in order to delay payment. Such requests will be reviewed on a case-by-case basis. Notwithstanding any of the foregoing, the Area Program's duty to pay an approved claim within thirty (30) calendar days after approval is not conditioned upon the Area Program first having received payment from the State for the services covered by the invoice.

Submission of Non-Medicaid Invoices to Area Program:

Area Programs shall include in their contracts with providers provisions concerning the submission of non-Medicaid invoices that comport with the following:

- The provider shall submit invoices for non-Medicaid services in the appropriate form within the shorter of: (a) the time period stated in the contract between the Area Program and provider and (b) 15 calendar days after the end of the month in which the service(s) was rendered, or in which the consumer was discharged from service. Failure to submit an invoice within the required time period shall exempt the Area Program from the time periods imposed by this section for approving, denying, requesting additional information for, and paying the invoice. In such circumstances, the Area Program shall process and pay the invoice within a reasonable time under the circumstances. If the Area Program denies payment of an invoice, the provider must resubmit the invoice, with full and complete information, as specified by the Area Program, within the shorter of (a) the time period stated in the contract between the Area Program and provider and (b) thirty (30) calendar days after provider's receipt of the denied invoice, unless the provider has received from the Area Program a waiver of the re-submission time period. Provider's failure to resubmit the invoice within forty-five (45) calendar days after provider's receipt of the denied invoice (absent a waiver from the Area Program) shall exempt the Area Program from the time periods imposed by this section for approving, denying, requesting additional information for, and paying the invoice. In such circumstances, the Area Program shall process and pay the invoice within a reasonable time under the circumstances.

Interest:

Payment due on an invoice that is not made within the time period required by this Section

IV.A.3. shall bear interest at the annual percentage rate of eight percent (8%) beginning on the date following the day on which the payment should have been paid. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Mail, first-class postage prepaid, properly addressed to the provider, or, if not mailed, on the date of the electronic transfer, or other actual delivery, of the payment to the provider. In paying any interest it owes to a provider under this provision, the Area Program shall use funds other than funds allocated to pay for services rendered to clients.

Third-Party Beneficiary:

Any provider who submits invoices to the Area Program for services rendered shall be an intended third-party beneficiary of this Section IV.A.3, and, without limitation, the duties imposed upon the Area Program through this section are likewise duties owed to such provider, and such provider may enforce the performance of the duties.

