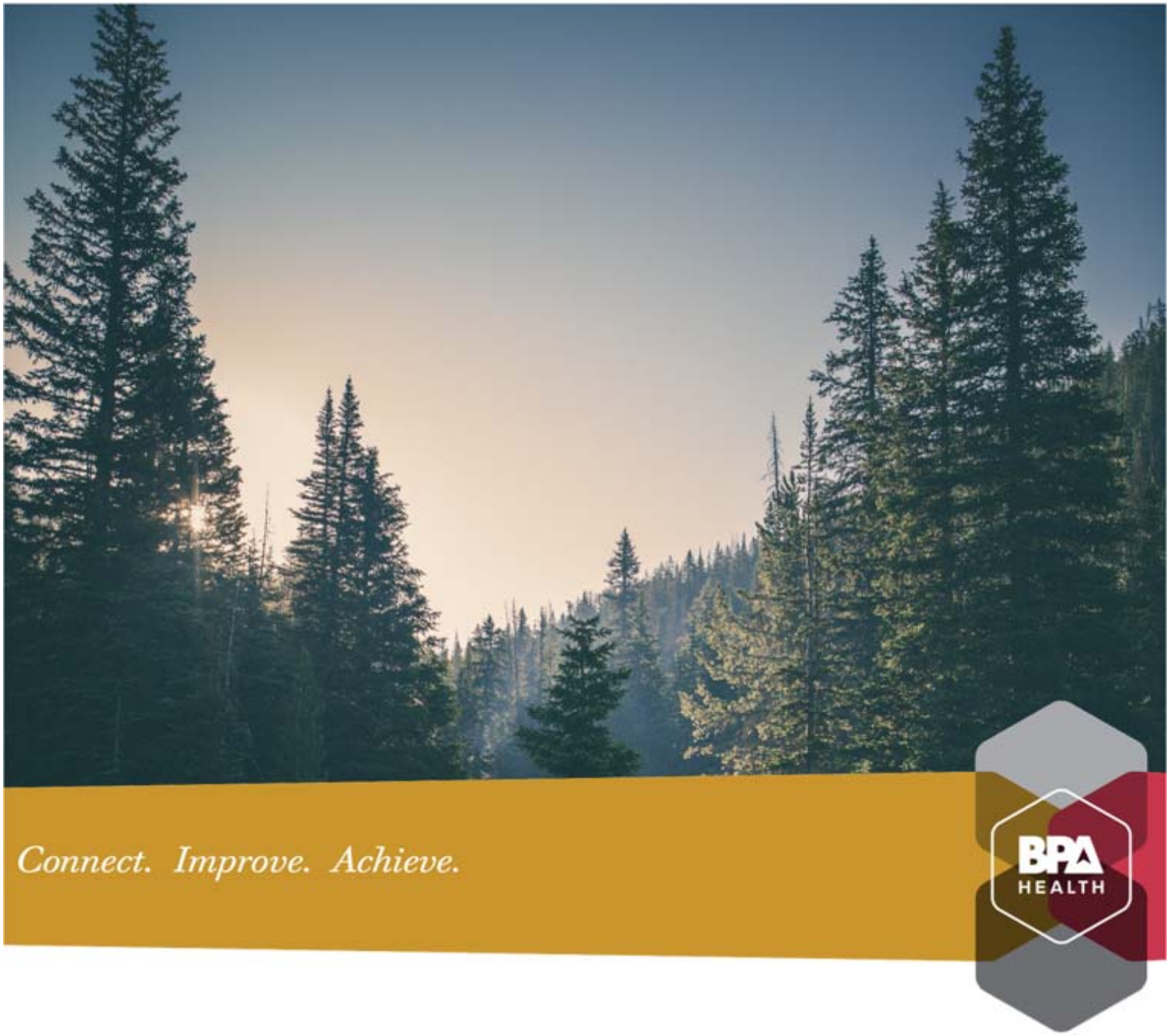


PROVIDER MANUAL

SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SUPPORT SERVICES NETWORK

2019

Last edited June 2019

8050 W. Rifleman St., Ste. 100
Boise, ID 83704
BPAHealth.com

Contents

1. About BPA Health and the State Funded SUD Program

BPA Health would like to welcome you to the Substance Use Disorder (SUD) Provider Network. BPA Health staff look forward to supporting your successes as a SUD Provider in your local communities through the consistency and expertise of our Provider Network Management and Quality, Evaluation, and Training team of professionals.

We believe personal contact fosters strong links with providers especially when dealing with sensitive matters. Our staff are trained, dedicated, and understand the importance of providing positive and professional support to the SUD Providers around the state.

BPA Health's SUD Provider Network is managed specifically for providing services to clients who are eligible to receive State Funding for SUD services. We partner with Idaho Department of Health & Welfare (IDHW), Idaho Department of Juvenile Corrections (IDJC), Idaho Supreme Court (ISC) and Idaho Department of Corrections (IDOC) to manage funds for their populations.

Each of these Partners has a budget for funded treatment services, which is allocated by the State Legislature. Partners make decisions throughout each year based on current utilization and projections. When changes are necessary, BPA Health works hand-in-hand with Partners to assist in decision making, but each Partner determines how their funds are authorized.

Thank you for the important work you do and the excellent service you provide to our clients, and our communities.

We look forward to working with you!

2. Introduction

2.1 Company History

For over 40 years, BPA Health has pioneered behavioral health in Idaho & the Northwest. BPA Health connects people to services to improve lives and achieve positive outcomes. On the front lines of our work around the Northwest and nationally, we help people address problems that adversely affect their job performance, health, and overall wellbeing. Our established regional roots help us understand and link communities and resources like no large national corporation can. In addition, it is our deeply held belief that behavioral health is a critical part of overall health, which motivates our professionals to deliver services with all they have to offer – in mind, body and spirit.

2.2 BPA Health Communications

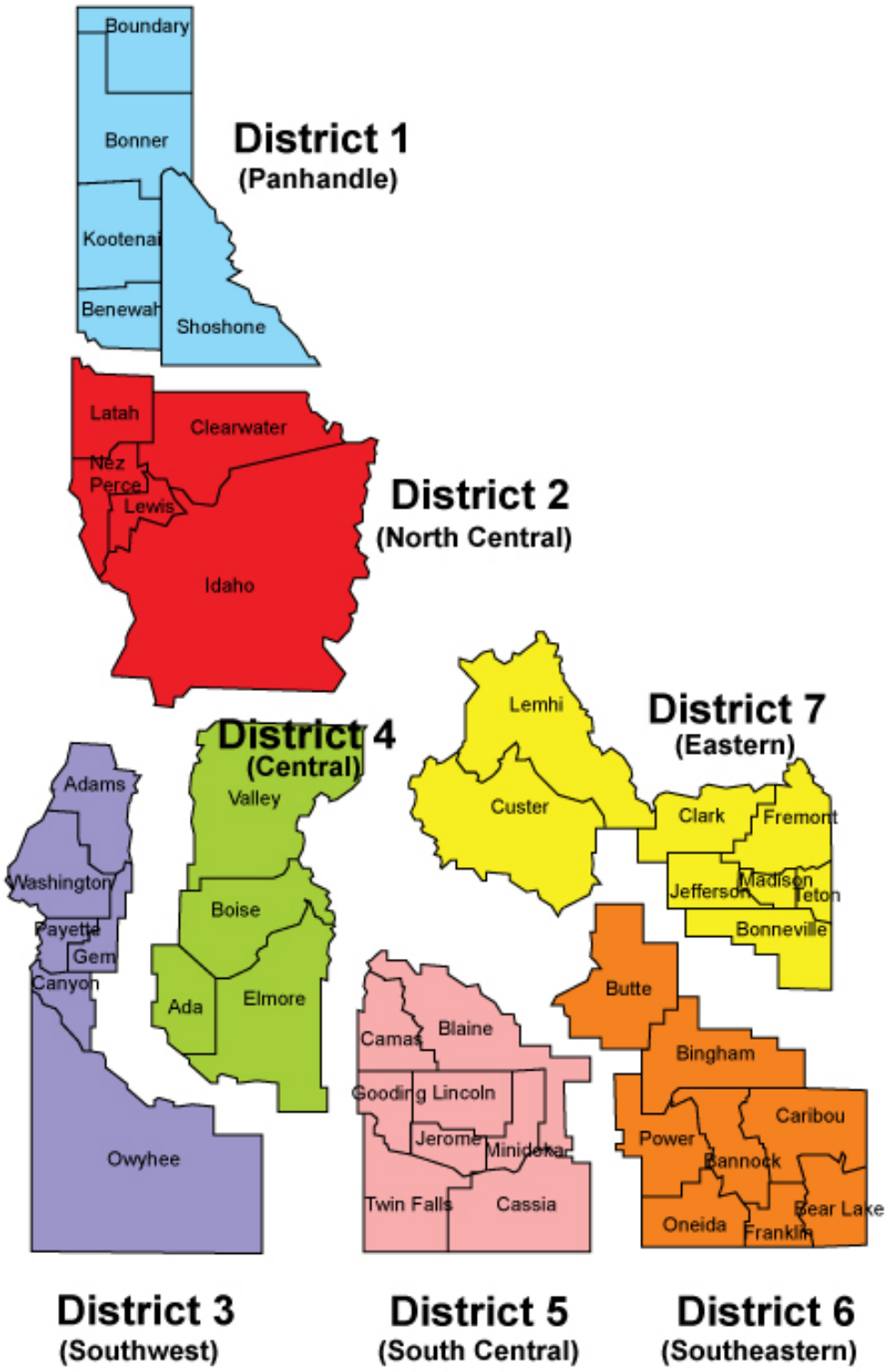
BPA Health will communicate with Providers directly, through email, Constant Contact, and through USPS as needed. BPA Health staff are available by phone Monday through Friday 8am – 6pm MDT, with exceptions for holidays and other state approved events. BPA Health will notify the Network in advance of any holiday or approved closures.

Please contact the Provider Network Management team at:
Email: providerrelations@bpahealth.com
Phone 1: 1-800-688-4013 toll free.
Phone 2: 208-947-4377
Fax: 208-344-7430

During regular hours of operation BPA Health staff should be able to reach a Network Agency staff member via phone, or leave voicemail. When the main contact phone number changes, BPA Health should be notified immediately. Network providers should maintain at least one working email account. BPA Health staff should be able to contact providers and when requesting information, receive a response within three business days.

Clinical Quality Coordinators (CQC): Communication and education liaisons between the provider and BPA Health. CQC's are a resource to providers and community stakeholders/referral sources for the State of Idaho Substance Abuse Treatment Delivery System.	Find your current CQC Contact information on our SUD Network Provider Resource Page
Claims For questions regarding claims payment, denials and submissions, not for submission of claims.	**(800) 922-3406** claims-dept@bpahealth.com
Care Management For questions regarding service authorization, and to speak to a Care Manager.	**(800) 922-3406**
Client Intake Phone screenings to determine eligibility for state funding.	**(800) 922-3406**
Quality, Evaluation & Training For questions related to surveys, appeals & complaints. For questions related to audit results and provider notifications. For questions related to trainings.	**(800) 922-3406** wecare@bpahealth.com bpaquality@bpahealth.com bpatraining@bpahealth.com

IDHW Regions/Districts:



2.3 BPA Health Website

The BPA Health website can be found at bpahealth.com. The menu link in the top right hand corner leads you to our search bar.

You can search our SUD Provider Network here. You can also find an index of important resources here, which includes our Provider Trainings page and Documents and Resources page.

We continue to add documents and update the search capabilities on our site. If you are unable to find what you're needing please call us at a number or email address above.

2.4 Purpose of the BPA Health Provider Manual

The purpose of this manual is to provide an overview of the State of Idaho's Substance Use Disorder System and specific information about BPA Health's system designed to administer the state contract. This manual is intended to be used in conjunction with the Behavioral Health IDAPA regulations, licensing and regulatory boards, as well as the BPA Health provider agreement and addenda. These documents create the foundation for which providers serving state-funded clients look to for guidance.

We hope this manual provides you with a clear understanding of our treatment philosophy and of the policies and procedures that must be observed when providing treatment and recovery support services to state-funded clients. We are committed to providing you support to help assure your success in the behavioral health care environment. We look forward to working with you and hope that you find your relationship with BPA Health is satisfying and rewarding.

2.5 Provider Credentialing and Contracting

BPA Health credentials and recredentials network providers to ensure that providers within our networks meet state and BPA Health credentialing standards. The goal is to:

- Ensure each BPA Health provider is qualified by education, training, licensure and experience to deliver quality behavioral health services
- Maintain only competent and qualified providers through appropriate parameters of credentialing and application of performance standards without discrimination based on race, age, color, religion, national origin or sex
- Provide a means to address issues of professional conduct, physical and psychological health status, and current clinical competence

As designated by the BPA Health Quality Management Committee (QMC) the Credentialing Committee (CC) has responsibility and authority for credentialing

and recredentialing the BPA Health provider network. BPA Health designates a Medical Director to review and approve credentialing and recredentialing applications. The Medical Director may conduct additional review and investigations of credentialing applications where the credentialing process reveals factors that may affect the quality of care or services delivered to clients.

BPA Health will only grant continued membership in the provider network to professionally qualified practitioners who:

- Demonstrate their current competence,
- Continuously meet and satisfy the qualifications, standards and requirements set forth.
- Practice in a geographic area determined by BPA Health to be advantageous to its clients
- Possess the necessary physical and mental health abilities to provide quality behavioral health services.

BPA Health's standard is to complete the credentialing and recredentialing process within 60 days of the receipt of a complete provider application and required documents. Prior to review, BPA Health will accept additional information from providers to correct incomplete, inaccurate, or conflicting credentialing information. Incomplete information or other extraneous factors may result in a delay of the credentialing process.

BPA Health will send written notification to the provider informing them of the determination of the credentialing application within 60 days of the determination.

2.6 Application Process

Applicants must complete a BPA Health application for participation in the network. Click here to access the application. All BPA Health online forms are HIPAA compliant.

> Submission of an application does not guarantee entry into the network, even when all application requirements are met. Prior to processing an application, BPA Health will review current SUD Network Capacity and Census information to determine if adding an Agency is beneficial for both the Agency and the Network.

For Agencies that provide clinical treatment services, the application will require documentation of Evidence Based Practices utilized by your programs, in addition to a Co-occurring capabilities self-assessment. These Agencies are also required to upload a copy of their current Behavioral Health Program Certificate. More information on this certification can be found on the Department of Health and Welfare website.

In an effort to provide continuity of care, BPA Health does not contract with 'assessment only' providers.

Required documents can differ based on the services the applicant will provide. BPA Health must receive all required documents before an application is considered complete and ready for review. Provider Network Management staff can assist you in determining if documents are needed.

All Agencies must provide proof of Criminal History Unit (CHU) *Enhanced* Background Check clearance for staff. This includes any staff member interacting face-to-face with, or accessing Protected Health Information for, State Funded clients. More information on this process can be found here: https://chu.dhw.idaho.gov/

All BPA Health providers are require to have insurance coverage, which differs based on services provided:

- Treatment providers: $1,000,000.00 per occurrence and $3,000,000.00 aggregate

- SUD standalone case management, recovery coaching and/or life skills providers: $1,000,000.00 per occurrence and $3,000,000.00 aggregate
- Commercial General Liability Insurance: Must show proof of, values are determined by the agency's policy.
- SUD Safe and Sober Housing provider: $1,000,000.00 per occurrence and $2,000,000.00 aggregate
- SUD Alcohol and Drug Testing providers: $1,000,000.00 per occurrence and $1,000,000.00 aggregate
- Auto Insurance: This refers to privately owned vehicles that are not used for the sole purpose of transporting clients. Must show proof of, at values aligning with Agency policy.
- SUD transportation providers: This refers to company owned vehicles, commercial vehicles, or vehicles contracted for the purpose of providing transportation to SUD clients. $1,000,000.00 per occurrence and $1,000,000.00 aggregate

Agencies submitting incomplete or incorrect applications; or erroneous information; will be contacted and given the opportunity to correct and complete the application process. Failure to provide requested information within 30 days may result in rejection of application. If extensions are needed for gathering correct documentations, please contact the PNM Department. Agency applications that are rejected due to being Incomplete and/or incorrect, will need to be resubmitted once corrections are made.

BPA Health may conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may affect quality of care or services delivered to consumers. BPA Health may contact the provider to request additional documentation not listed in the standard application

BPA Health will conduct primary source verifications of clinicians and certified staff. Primary source is defined as the organization or entity that originally conferred or issued an element used in credentialing or the data bank(s) to which those organizations report.

Provider agencies must complete WITS (Web Infrastructure for Treatment Services) trainings and BPA Health Provider Orientation prior to activation in the network. For WITS Training information, and related paperwork, please contact WITS by calling 208-332-7316. Once your WITS trainings are complete, BPA Health Quality, Education, and Training (QET) staff will reach out to you to complete your Provider Orientation.

BPA Health may require additional WITS trainings or Orientation after periods of inactivity (no active SUD Funded Client authorizations), or as deemed necessary by any BPA Health Department or Committee.

2.7 Adding or Removing Staff

Providers must complete the staff update form located on the BPA Health website for all new staff members and for any staff that leaves the organization. This form must be completed within 24 of a staff member being hired or leaving. Additionally, providers must notify the WITS helpdesk within 24 hours of a staff member leaving to ensure WITS access is terminated. The WITS form is located on the WITS website**.** Failure to comply with either of these may result in sanctions.

Please use this online form to both add to, and remove employees from, your current staff roster.

2.8 Address Changes, Removals, and Requesting Additional Sites

Providers are contractually obligated to provide notice to BPA Health prior to changing geographic locations (change of address). Failure to report a change of address may result in Agency sanction or termination. Agencies utilize the SUD Add/Remove Address Form for make the required notifications.

This same form is used to request additional Agency locations be contracted in the Network. Submitting a request add sites to the Network is not a guarantee of entry. Prior to processing this request BPA Health will review current SUD Network Capacity and Census information to determine if adding an Agency is beneficial for both the Agency and the Network.

Address changes, additions and removals take an average of 60 days to process. This timeframe is an important planning consideration and can potentially result in a temporary loss of referrals due to service inactivation. In cases of inactivation, providers are responsible for requesting transfer of client authorizations to other Agencies.

Providers completing a change of address form are responsible for requesting transfers of client authorizations to their new location. BPA Health staff will notify a provider when their change of address, or additional site has been approved, activated, and created in WITS. Transferring authorizations may require coordination with other Agencies.

2.9 Credentialing Committee

The BPA Health Credentialing Committee has an overall responsibility for administering credentialing and recredentialing decisions related to or affecting providers and organizations in a BPA Health provider network. The Committee reviews credentialing and recredentialing, provides ongoing monitoring, and makes recommendations concerning provider sanctions. Committee members include:

- Medical Director
- Clinical Director
- Director of Provider and Client Services
- At least one practicing provider who has no other role at BPA Health.

The Credentialing Committee is authorized to review the scope of clinical practice as well as the professional conduct and clinical performance of each provider. The Credentialing Committee must approve all credentialing applicants before a provider or facility is designated as a participating provider within the plan's network. In an effort to expedite processing, the Medical Director may allow an Agency into the network prior to review by the full Credentialing Committee.

In addition to credentialing and recredentialing providers, the Credentialing Committee can also terminate, restrict or limit a provider's clinical privileges (e.g., based on quality of care and/or services issues). In these situations, the provider may enter into the Adverse Action Appeals process (see BPA Health website for additional information). The Credentialing Committee can require providers obtain additional trainings or supervision, or choose to deny providers who are requesting an initial credentialing and present a concern of any kind.

Decisions made which are unfavorable to the provider will be reported to National Practitioner Data Bank, state licensing board(s), or other certification entity, as required after the provider has exhausted the appeals process. If the provider does not agree with decisions or actions, the provider is entitled to a review under the Adverse Actions Appeals process. BPA Health will provide written notification to the provider when a professional review action has been brought against the provider. The reason for the action and a summary of the appeal rights and process will be provided.

3. Definitions and Acronyms

3.1 Definitions

42 CFR, Part 2*:* Federal confidentiality rules that prohibit the disclosure of information concerning a client in alcohol or drug treatment unless further disclosure is expressly permitted by the written consent of the person who it pertains or otherwise permitted by 42 CFR, Part 2. Please note that to reduce stigma associated with substance abuse, this rule defines the required confidentiality and privacy for substance abuse treatment across the country. It is far more restrictive with regard to disclosure than HIPAA.

American Society of Addiction Medicine (ASAM) Criteria: The ASAM criteria helps clinicians, counselors, and care managers develop patient-centered service plans and make objective decisions about patient admission, continuing care, and transfer/discharge for individuals with addictive, substance-related, and co-occurring conditions. Through their multidimensional assessment and the continuum of care, the criteria can improve patient outcomes. The third edition was released in 2013. Website: https://www.asam.org/resources/the-asam-criteria.

Assessment: The collection of data necessary to identify areas of concern and functioning and may be used to develop an individualized treatment and case management strategy aimed at eliminating or reducing alcohol/drug consumption. The assessment utilizes a thorough evaluation of the person's physical, psychological, and social status, a determination of the environmental forces that contribute to the alcohol/drug using behavior, and examination of the person's support systems and resources.

> **Note**: The required minimum assessment tool for court ordered clients with state funding is the Global Assessment of Individual Needs-CORE (GAIN-CORE) or GAIN-I. An individual trained and certified as a GAIN site administrator must administer the GAIN assessment. Non-court ordered IDHW clients may complete a GAIN-LITE assessment. Additional tests/measurements may be used to assist in defining the needs to be addressed (e.g., BECK depression scale, mental health screenings, ASI, SASI, and Socrates).

Assessment Building System (ABS): The GAIN Assessment Building System (ABS) is a HIPAA-compliant, web-based system hosted by Chestnut Health Systems that allows for computer-based and interactive administration of the GAIN instruments. Individuals utilizing this system must have authorization to access through WITS and be certified and approved by IDHW in GAIN administration. Website: http://www.gaincc.org/abs.

Authorization: Authorizations in WITS identify funding source (contract), service, and allowable units for reimbursement, and allowable period to use units. Authorizations are provided to pay for clinical treatment and recovery support services for eligible recipients from a network provider. Authorizations are provider and site specific and are sent to the provider chosen by the eligible recipient.

Authorization Change Request (ACR): The documentation required to submit a utilization review in WITS including initial clinical reviews, concurrent reviews, change to service(s) request, request for a new service(s), and updates to authorization span and units. Some ACRs require accompaniment of ASAM documentation in order for a clinical determination to be made by the UM team. Some ACRs do not require ASAM documentation.

Authorized Services: Means those Covered Services that are medically necessary and pre-authorized by BPA Health.

BPA Health (BPA): Managed Behavioral Health Organization that serves as the Management Services Contractor (see MSC definition) for the State of Idaho Substance Abuse Treatment System. Website: http://www.bpahealth.com

BPA Health Care Manager: Healthcare professional delivering utilization management (UM) services defined as: Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services. UM encompasses prospective, concurrent and retrospective review as well as any review of services where authorization is required in which clinical criteria are applied to a request. Care Managers are also responsible for care coordination activities.

BPA Health Recommended Forms: Refers to those Word documentation examples produced by BPA Health as having the required IDAPA and ASAM elements. Providers have the option to utilize these forms in their current format or reformat them to fit their respective agency or EHR needs. **Note:** The elements in the recommended forms must remain intact to meet IDAPA Standards.

BPA Health Representative: A health care professional who is employed by BPA Health to provide oversight of administrative activities for contracted behavioral health care services for BPA Health Eligible Members.

BPA Health Required Forms: Refers to those PDF documentation examples produced by BPA Health that cannot be edited. These documents are found on our website.

Bureau of Substance Use Disorders: A program within the IDHW Division of Behavioral Health that is responsible for the statewide delivery system of substance abuse clinical treatment and recovery support services.

Case Management (CM): Case management is a collaborative process that assesses, plans, links, coordinates, monitors, and advocates for options and services required to meet the client's health and human service needs.

Charitable Choice: Defined by Community Block Grant (CSBG), Substance Abuse and Mental Health Services Administration (SAMHSA) as religious organizations that receive Federal funds must serve all eligible participants regardless of those persons' religious beliefs. In addition, recipients of services provided under Charitable Choice laws have the right to be provided with services from a non-religious provider. Recipients should be offered a choice of providers.

Client: A person/consumer/individual receiving services from the program for substance use disorders (SUD) services. This term may be used interchangeably with eligible recipient (see definition of eligible recipient).

Client ID Number: WITS-generated unique identification number (UCN) to identify clients within WITS. Can be used on hard copy clinical files.

Clinical Quality Coordinator (CQC): BPA Health clinical employees that mentor behavioral healthcare facilities, act as a liaison with BPA Health offices, provide training, and assist in problem solving. CQCs monitor the requirements of the provider contracts with BPA Health and the State agencies contracting for the SUD services.

Clinical Supervisor (CS): A clinician who meets BPA Health's qualifications for the licensure/certification, education, and work experience qualifications of clinical supervisor. More details can be found in Section 4.3 and in the BPA Health Supervision Manual.

Comprehensive Case Management Service Plan: A comprehensive service plan is based upon a current approved assessment that addresses the medical, social, psychosocial, legal, educational, and financial needs of the client for Case Management services. The Comprehensive Case Management Service Plan provides for the coordination of services across multiple need domains.

Co-occurring Disorders (COD): The occurrence of a mental health and substance related disorder(s) as defined in the current DSM and diagnosed by someone with the licensed capacity to assess and diagnose. Also referred to as dual diagnosis.

Covered Services: means the medically necessary services that are provided for by IDHW rules or programs and that BPA Health is responsible for coordinating and authorizing for Eligible Members.

Critical Incident: A Critical Incident is an event that caused, or could have caused, physical or emotional distress to staff, visitors, or the participants of the program. Critical Incidents are outside the normal day-to-day range of experience of the people involved or witnessing the event. A Critical Incident is including, but not limited to, any event or events that threatens the safe and efficient operations of any provider or of the Contractor, or any event involving violence or serious injury involving a client who received services within the last thirty (30) days or death of a former client other than natural causes up to a year after discharge. Critical Incidents will include, but not be limited to the following:

a. Death that is related to client's condition, such as a motor vehicle accident, accidental overdose or medical condition that is related to substance use disorder.
b. Suicide attempts or completions
c. Actual, alleged or suspected cases of violence, abuse, neglect exploitation, or threats of minors or vulnerable adults (as defined in Idaho statutes).
d. Any facility or provider related event that will substantially interfere with care.
e. Any facility or provider break-in resulting in missing or stolen client files.
f. Improper use or disclosure of patient records covered under CFR 42 and HIPAA.
g. Major disaster or accidents affecting the location or well-being of clients.
h. Employee criminal activity resulting in arrest, detention, or involvement with law enforcement

Customer Support Specialists: Primary contact point for all BPA Health interactions with providers and clients. The Customer Support staff is responsible for conducting initial telephonic screenings and determining funding eligibility, answering questions regarding service vouchers, service authorization, and triaging calls to the correct department for resolution. Customer Support staff can be reached at *1-800-922-3406 (this number also provides 24 hour access to crisis counselors).*

Domains: Specific bio-psycho-social assessment areas as defined by ASAM; six (6) dimensional criteria: acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and, recovery/living environment.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults including Substance Use Disorders. It is used to better understand illnesses and potential treatment.

Eligible Member: An individual who is eligible to receive the IDHW's Substance Use Disorder treatment program services at the time services were provided.

Evidence Based Programs and Practices (EBP or EBPP): Clinical programs and practices that research has shown to be effective in improving treatment outcomes.

For-Cause Audit: Mandatory audit in suspected cases of abuse, quality of care or compliance concerns, or other serious violations of state and federal regulations.

Global Appraisal of Individual Needs (GAIN): State Approved assessment tool as identified in IDAPA Code.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information. Website: http://www.hhs.gov/ocr/privacy/

IDAPA-Refers to the Idaho Administrative Procedures Act which sets requirements for all Alcohol and Substance Use Disorders Treatment or Recovery Support Service Facilities and Programs.

Intensive Outpatient (IOP): An organized non-residential service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a structured program, for a minimum of 9 hours of treatment per week for adults and 6 hours of treatment per week for adolescents (not including Recovery Support Services). **Note**: IDOC authorizations for IOP differ dependent upon Stages of Treatment Benefits plan additional information on plan limitations are noted in the IDOC Rate Matrix.

Level of Care (LOC): A level or modality of care is a step in the client's treatment process. A level of care includes clinical services, and may also include care coordination and recovery support services. Each time a client moves from one level of care to another, the clinician will be required to document the clinical observations justifying the change.

Life Skills (LS): Life Skills programs are non-clinical services designed to enhance personal and family skills for work and home, reduce marriage/family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community.

***Management Services Contractor (MSC*)**: The organization (currently BPA Health) that contracts with Idaho Department of Health and Welfare Bureau of Substance Use Disorders to manage the statewide delivery system of substance abuse clinical treatment and recovery support services. Responsibilities of the MSC include: utilization review and care management services, quality management and outcome assessment, management reporting, account management, claims processing, data collection, and managing the provider network.

MAT (Medication Assisted Treatment): Prescribed medication for use in the treatment of addiction.

Medically Necessary-means those Covered Services and facility charges that are provided for under IDHW rules or programs and determined by BPA Health to be:

a. Appropriate for the symptoms and diagnosis or treatment of a condition, illness or:
b. Provided for the diagnosis or the direct care and treatment of the condition, illness or injury.
c. In accordance with the standards of good medical practice in the service area.
d. Not primarily for the convenience of a plan member or a plan provider.
e. The most appropriate level or type of service or supply which can safely be provided to the plan member and
f. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals.

***Note To Authorizer (NTA)*:** A type of ACR that does not require clinical documentation.

Not To Exceed (NTE): Not to exceed service limits (within identified periods or per authorization) identified in the Rate Matrix.

Outpatient (OP): An organized non-residential service, delivered in a variety of settings, in which addiction and mental health treatment personnel provide professionally directed evaluation and treatment for substance-related, addictive, and mental disorders. This also includes the services of an individual licensed practitioner (8 hours or less of treatment per week for adults and 5 hours or less of treatment per week for adolescents, not including RSS services). **Note**: IDOC authorizations for OP differ dependent upon Stages of Treatment Benefits plan– additional information on plan limitations are noted in the IDOC Rate Matrix.

Partners: The term "Partners" applies to the four main State agencies who oversee the State SUD contract. Partners include Idaho Department of Health and Welfare (IDHW), Idaho Department of Corrections (IDOC), Idaho Department of Juvenile Corrections (IDJC), and Idaho Supreme Court (ISC).

Pre-Treatment: IDOC's early intervention treatment modality to determine readiness and appropriateness for entering/engaging in treatment. Pre-Treatment period is not to exceed 60-days without clinical justification and coordination with Probation/Parole. As soon as clients begin to consistently attend 50% of scheduled services they should complete GAIN assessment, and if appropriate, enter treatment. **Note:** Applies to IDOC populations only.

Protected Health Information or "PHI" means an Eligible Member's 'individual identifiable health information' as defined in 45 C.F.R. and 42 C.F.R. § 160.103 and/or applicable state law.

Provider: An agency that possesses a current Behavioral Health Program approval granted by IDHW under IDAPA 16.07.15 and 16.07.17 *et seq.*, who is also approved and has entered into an agreement with BPA Health to provide Substance Use Disorder Services to member's authorized. Or, An agency who has entered into a contractual arrangement to provide covered services for those treatment modalities checked on the provider application and reimbursement matrix.

Provider Notification: BPA Health's electronic notification process for the delivery of timely information to the SUD Provider Network.

Quality, Effectiveness and Compliance (QEC) Audit: Review of client charts for quality and effectiveness of services compliance with IDAPA and BPA Health standards.

Rate Matrix: Reimbursement and CPT code schedule for all funding streams including frequency, duration and maximum allowable services.

Recoupment: Process of repaying claims for items of over payment, incomplete billing, unsubstantiated billing, or other concerns where payment in excess of authorized and appropriate payments have been made**.**

Recovery Coach(ing): A personal guide and mentor for people seeking or in recovery. The Recovery Coach helps to remove barriers and obstacles, and links the recovering person to the recovery community. Recovery Coaching provides the client with a person that can act as a mentor, ally, role model, motivator, problem solver, resource broker, advocate, and/or community organizer.

Recovery Support Services (RSS): Approved non-clinical substance abuse services designed to engage and maximize the ability of Eligible Recipients to be successful in their recovery, and to live productively in the community. Recovery Support Services are initiated with the client at the earliest possible point in the individual planning and service delivery process.

Release of Information (ROI): Required documentation signed by the client and/or representative for the release of specifically identified information. See 42 CFR, Part 2 / HIPAA regulations.

Residential Treatment:

Level III.1: Adult Halfway House - ASAM refers to this level of care as Clinically Managed Low-Intensity Residential Services.

Level III.1: Adolescent Transitional - ASAM refers to this level of care as Clinically Managed Low-Intensity Residential Services.

Level III.2: Adult Social Detox – ASAM refers to this level of care as 3.2 WM Clinically Managed Residential Withdrawal Management.

Level III.5: Adolescent Residential – ASAM refers to this level of care as Clinically Managed Medium-Intensity Residential Services.

Level III.5: Adult Residential - ASAM refers to this level of care as Clinically Managed Medium-Intensity Residential Services.

Level III.7: Adult Medically Monitored Residential
ASAM refers to this level of care as Medically Monitored Intensive Inpatient Services

Secure Email: Email system that meets all HIPAA and 42 CFR, Part 2 Federal requirements for the secure transmission of PHI and/or related information to/from BPA Health and/or any other entity requesting such communication. BPA Health uses ZIX email.

Service Plan: Per IDAPA 16.07.15, "Each participant must have an individualized service plan. The development of a service plan must be a collaborative process involving the client and other support and service systems." The Individualized Service Plan uses the IDHW approved comprehensive assessment for identified problem areas to develop goals, and treatment interventions specified for the client. IDAPA 16.07.15 states that "The responsibility for the development and implementation of the service plan will be assigned to a qualified behavioral health professional." Exception to service plan requirement include IDOC funded clients who are in pre-treatment and those in Parolee aftercare for 60 days or less.

Specialty Provider: SUD Provider meets additional specific requirements and is authorized to provide services to specific populations (e.g., Pregnant Women & Women with Children (PWWC) and Criminal Justice Network).

Staffing (planned facilitation): Staffing (planned facilitation) is to be used by professional staff for face-to-face collaboration with external collateral sources and for completion and submission of IDOC monthly Status Report forms for IDOC funded clients.

Substance Abuse and Mental Health Services Administration (SAMHSA): The Federal agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Website: http://www.samhsa.gov

Substance Use Disorder (SUD): a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems marks Substance use disorder.

Supervision Audit: Review of staff supervision files for compliance with IDAPA and BPA Health standards.

Treatment Episode: A treatment period that begins with admission to clinical treatment and ends with the last authorized service date.

Treatment Provider: Organization approved by the Idaho Department of Health & Welfare Bureau of Substance Use Disorders to provide clinical treatment services to individuals with substance abuse disorders.

WITS: WITS is a web-based application and database that serves dual purposes, a management information system (MIS) and clinical documentation tool. As an MIS tool, the system allows the Division of Behavioral Health to meet current and emerging state and federal reporting requirements. As a clinical documentation tool, WITS provides an agency the ability to create a full electronic health record compliant with HIPAA and 42-CFR part II standards. Website: http://wits.idaho.gov/

3.2 Acronyms

ACRA: Adolescent Community Reinforcement
ASAM: American Society of Addiction Medicine
APS: Adult Protection Services
CBI-SA: Cognitive-Behavioral Intervention
CLAS: Culturally and Linguistically Appropriate Services
CM: Case Management
CPS: Child Protection Services
CQC: Clinical Quality Coordinator
CQIP: Continuous Quality Improvement Program
CTS: Change to service
DBH: Department of Behavioral Health
DT: Drug Testing
EBP: Evidenced Based Practices
ESSH: Enhanced Safe and Sober Housing
FF Trans: Flat fee transportation
IBADCC: Idaho Board of Alcohol/Drug Counselor Certification
IBOL: Idaho Board of Occupational Licensing
IDHW: Idaho Department of Health & Welfare
IDJC: Idaho Dept. of Juvenile Corrections
IDOC: Idaho Dept. of Correction
IOP: Intensive Outpatient
IROC: Idaho Response to the Opioid Crisis
ISC: Idaho Supreme Court
LS: Life Skills
LSI-R: Level of Service Inventory
MAT: Medication assisted treatment
MM Res: Medically monitored residential
NPDB: National Practitioner Data Bank
OM: Out of matrix
OP: Outpatient
OUD: Opioid Use Disorder
PA: Parolee aftercare
PNM: Provider Network Management
PWID: Persons Who Inject Drugs

PWWC: Pregnant women and women with dependent children
Pre-tx: Pre-treatment
QET: Quality, Education, and Training
QP: Qualified Professional
RC: Recovery coaching
Res: Residential
RSS: Recovery Support Services
RTR: Risk to Revocate
SABG: Substance Use Prevention and Treatment Block Grant
SAMHSA: Substance Abuse and Mental Health Services Administration
SOR: State Opioid Response
SSH: Safe and sober housing
STR: State Targeted Response
TBH: Tele-Behavioral Health
UCN: Unique client number
UM: Utilization Management
WITS: Web Infrastructure for Treatment Services

4. Provider Rights and Responsibilities

Providers have specific rights and responsibilities as participants in the BPA Health Network, and as agreed to in the Substance Use Disorder Provider Agreement, Amendment, and partner-specific addendums.

4.1 Provider Rights

1. Providers will be informed via initial application packet letter of:
   a. Their right to review the information obtained to evaluate their credentialing decision, attestation, or resume and Curriculum Vitae.
   b. The process and provider's right to be informed of the credentialing decision.
   c. Provider's right to correct erroneous information (see below); 4) the appeal process for actions taken against providers (see below and Provider Termination & Sanction Policy).
2. Providers have the right to review information obtained by BPA Health to evaluate their (re)credentialing applications except where disclosure is protected by peer review or prohibited by law.
3. Discrepancies of information:
   a. For information obtained during verification from primary sources providers have the right to correct discrepant or erroneous information by working directly with the reporting entity or listing agency.

b. If the credentials verification process reveals information that varies substantially with the information supplied by the provider on the (re)credentialing application the provider is notified by a staff member of BPA Health and given the opportunity to respond to inconsistent information on the (re)application. The provider will have ten calendar days to provide a response in writing. The provider's response and corrected information is documented in the credentialing file. It is the responsibility of the provider to contact the primary source if the provider feels that the primary source data is incorrect.

4. Status of credentialing application
   a. Providers have the right to request the status of their application at any time.

4.2 Provider Responsibilities

The Substance Use Disorder Treatment Provider must provide Evidence-Based modalities in compliance with IDAPA and BPA Health requirements to state-funded clients. In order to receive BPA Health referrals, providers must contract and credential with BPA Health.

To comply with the BPA Health contract agreement BPA Health providers agree to the following:

1. Provide covered services authorized by a BPA Health representative to Eligible Members. Covered services shall be provided in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment and in accordance with Idaho Administrative Procedures Act (IDAPA) and applicable plan documents. Provider shall ensure that all personnel providing services to clients under the Provider agreement provide such services in an ethical and professional manner, and in compliance with all applicable laws and regulations, including state licensure boards. *Reference: 2.1 of the SUD Provider Agreement*.
2. Providers shall strictly comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including without limitation, laws applicable to telehealth and protected health information. *Reference 1.1 of the SUD Provider Amendment*.
3. Complete and maintain clinical records on eligible clients, to whom services are rendered, as required by the State of Idaho for providers as specified in IDAPA. BPA Health shall have the right to access and copy records of eligible clients for a period of five (5) years after termination of the Provider Agreement. *Reference: 2.2 of the SUD Provider Agreement.*

4. Treatment providers must maintain an active State Facility Certificate of Approval to receive SUD funding as defined by IDAPA. *Reference 2.3 of the SUD Provider Agreement.*
5. Shall not discriminate against eligible clients on the basis of source of payment, race, color, creed, sex, ethnicity, nationality, age, state of health, place or residence, disability or perceived disability, or any other basis prohibited by law. *Reference 2.4 of the SUD Provider Agreement.*
6. Must maintain appropriate insurance coverage. Provider shall also (a) supply upon reasonable request a copy of the face sheet reflecting any changes in insurance coverage prior to their effective date; (b) supply copy of the face sheet for each annual renewal of the provider's insurance. Provider shall immediately notify BPA Health in the event of termination or non-renewal of such insurance (See Section 2.4 of Provider Manual for the amount of insurance required). *Reference 2.5 of the SUD Provider Agreement.*
7. Unless prohibited by law, promptly notify BPA Health of the initiation of litigation by any third party or the initiation of any state or federal investigation and of any facts or circumstances which indicate the possibility that a third party has a cause of action or will initiate litigation, with respect to any act or omission of provider or BPA Health, or any employees, agent, or contractor of provider or BPA Health. *Reference 2.6 of the SUD Provider Agreement.*
8. Consents to the listing of his/her name in BPA Health's directory or in the directory or other publications of any organization with which BPA Health has contracted to arrange for the provision of behavioral health care services or Idaho Department of Health & Welfare funded Substance Use Disorder services. *Reference 2.7 of the SUD Provider Agreement.*
9. Not advertise or distribute material, which refers to BPA Health without BPA Health's prior written consent. *Reference 2.8 of the SUD Provider Agreement.*
10. Comply with all reasonable administrative policies and procedures of BPA Health relating to the delivery of covered services including, but not limited to timeliness standards and procedures to request additional services beyond those initially authorized. *Reference 2.9 of the SUD Provider Agreement.*
11. Agree that during the course of the Provider agreement and at all times thereafter, he/she shall hold confidential all information concerning BPA Health, BPA Health providers and eligible clients. *Reference 2.10 of the SUD Provider Agreement.*

12. Comply with all IDHW and BPA Health required standards as outlined in IDAPA and BPA Health Provider Manual. *Reference 2.11 of the SUD Provider Agreement.*
13. Agree to accept eligible clients upon referral from a BPA Health representative. If provider cannot meet the requirements of the referral, the provider must promptly notify BPA Health. *Reference 2.12 of the SUD Provider Agreement.*
14. Agree to allow appropriate BPA Health representatives, upon request, to inspect its facilities and its medical records of eligible clients. *Reference 2.13 of the SUD Provider Agreement.*
15. Agree to comply and cooperate with the BPA Health Quality Assurance Program including, but not limited to, Evidence Based Practice audits, outcomes and satisfaction assessment process, Continuous Quality Improvement (CQI), charitable choice requirements, co-occurring outcomes and the credentialing process. These elements will be pursuant to HIPAA and 42CFR privacy rules to ensure the limited purpose of evaluating for compliance, review competence and or qualifications of providers by evaluating their performance. These audits/reviews are not used for the purpose of any study or for direct client contact. *Reference 2.14 of the SUD Provider Agreement.*
16. Provider agrees to follow the Code of Ethics as adopted by the provider's license and/or certificate related national professional association. *Reference 2.15 of the SUD Provider Agreement.*
17. Notify BPA Health within ten (10) working days from receipt of notice to the agency or any personnel providing services pursuant to the Provider Agreement termination, non-renewal, or restriction of license, certificate, registration, or other legal authorization to provide any behavioral health services. *Reference 2.16 of the SUD Provider Agreement.*
18. Submit appeals for non-certification or claims payment denial decision and complaints using BPA Health's Appeals (How To) reference guide and Complaints (How To) reference guide, available on the BPA Health website. Submit appeals for adverse actions, such as suspension or termination, using the adverse Action Appeals (How To) reference guide on the BPA Health website. *Reference 2.17 of the SUD Provider Agreement.*

19. SUD Faith Based Providers must comply with Charitable Choice laws as outlined in the Federal Community Services Block Grant and Substance Abuse and Mental Health Services. *Reference 2.18 of the SUD Provider Agreement.*
20. Notify BPA Health thirty (30) days prior to any service site relocation or addition of new service site. Any new service sites must go through BPA Health's established application and credentialing process. *Reference 2 of the SUD Provider Agreement.*
21. Comply with required provider trainings. *Reference 2.20 of the SUD Provider Agreement.*
22. Report critical incidents as outlined in the Critical Incident Reporting Requirements and reporting form available on the BPA Health website. *Reference 1.7 of the SUD Provider Amendment.*
23. Maintain HIPAA compliance for electronic claims submission. *Reference 2.22 of the SUD Provider Agreement.*
24. Comply with the requirements of the GAIN/WITS interface as outlined by IDHW and BPA Health. *Reference 2.23 of the SUD Provider Agreement.*
25. Ensure that all personnel providing services to eligible clients under the Provider Agreement are properly trained and qualified per IDAPA and the BPA Health Provider Manual to render the services they provide. Provider shall arrange for continuing education of personnel rendering services under the Provider Agreement as necessary to maintain such competence and satisfy all applicable licensing or other legal or regulatory requirements. *Reference 2.24 of the SUD Provider Agreement.*
26. Neither Provider nor any person providing services to eligible clients shall have been barred or excluded from participating in any federal health care program, including Medicaid. *Reference 2.25 of the SUD Provider Agreement.*
27. Providers shall provide verification of enhanced criminal history clearance for all staff to BPA Health Provider Network Management pursuant to IDAPA 16.05.06 or a criminal history clearance waiver if eligible per IDAPA 16.07.15. *Reference 1.2 of the SUD Provider Amendment.*
28. Provider agrees to participate, if selected, in the Independent Peer Review of the State. *Reference 1.3 of the SUD Provider Amendment.*

29. Treatment Providers shall refer clients who use needles with HIV/AIDS/Infectious Disease to testing facilities and appropriate treatment providers. Patients must be admitted into treatment within 14 calendar days upon determination as an Eligible Member. No program funded through the Block Grant funds shall provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. *Reference 1.4 of the SUD Provider Amendment.*
30. Treatment providers must meet co-occurring capability criteria per BPA Health Co-occurring Assessment and maintain co-occurring disorders policies and procedures. *Reference 1.5 of the SUD Provider Amendment.*
31. Providers will utilize WITS for the purpose of billing and documentation and comply must with the requirements of the WITS interface as outlined by IDHW and BPA Health. Treatment providers must comply with the requirements of the GAIN ABS interface as outlined by IDHW and BPA Health. Remove/void section from section 2.23 of BPA Health Substance Use Provider Agreement, Replace with this section. *Reference 1.6 of the SUD Provider Amendment.*
32. Provider will report Critical Incidents in accordance with BPA Health's Critical Incident Reporting Policy and Procedure. *Reference 1.7 of the SUD Provider Amendment.*

4.3 Staff Qualifications and Supervision Requirements

All Providers (treatment and RSS) are expected to maintain a workforce of qualified, appropriately trained staff and to ensure that staff update forms (located on BPA Health website) are completed and submitted whenever staff are added to or leave a provider agency. Staff qualifications will be verified at time of application and time of any staff turnover. All staff involved in patient care or who has access to PHI must show proof of an enhanced criminal background clearance.

Treatment Providers

Treatment provider agencies must employ qualified clinical staff and a clinical supervisor and use an evidence-based model for clinical supervision. The clinical staff at a treatment provider agency must meet qualifications of a QSUDP of a QSUDPT as follows:

1. Qualified SUD Professional per IDAPA 16.07.17 section 200, or
2. Qualified SUD Trainee (QSUDPT) per IDAPA 16.07.17 section 210 AND who meets the following additional BPA Health Standards:
    a. Formal documentation as Certified Idaho Student in Addiction Studies (ISAS); or
    b. Formal documentation as a Northwest Indian Alcohol/Drug Specialist Counselor I; or

c. Formal documentation of current enrollment in an accredited program in accordance with the qualifications of IDAPA 16.07.17 IDAPA Section 200of these rules.
d. NOTE: *STUDENTS ENROLLED IN CADC PROGRAMS, MUST HAVE ISAS before working with clients*.

3. An individual who has completed a program listed in IDAPA16.06.17 Section 200 and is awaiting licensure can continue as a QSUDPT at the same agency for a period of six (6) months from date of program completion. Individuals may not continue as a trainee for a period of more than three (3) years.

The qualifications for a Clinical Supervisor include a combination of education and experience as follows:

1. Clinical Supervisor designation from the Idaho Board of Occupational Licensure and professional experience in provision of substance use disorders treatment; or master's degree from an accredited, approved, and recognized college or university in health and human services and (3) years paid full-time professional experience with two (2) years providing direct substance use disorders treatment professional experience providing direct substance use disorders treatment.
2. IBADCC Certified Clinical Supervisor with professional experience in the provision of substance use disorder treatment.
3. If supervising individuals providing services to adolescents, the experience must include working with children and adolescents and a working knowledge of child and adolescent growth and development, and the effects of alcohol and drugs on a child's growth and development.

Approval of a provider's clinical supervisor will be determined at application or when completing the staff update in the case of change of clinical supervisor for the agency. Please note: Clinical Supervisors can't supervise their supervisors, business partners, or family members.

Clinical Supervision Requirements:
BPA Health trains to the NWATTC Model of clinical supervision. If a provider would like to use a different evidence-based model this first needs to be approved by BPA Health. The BPA Health Supervision Manual further details the supervision requirements. It can be found on our website at BPAHealth.com.

Clinical Supervision for Trainees (including ISAS and interns)

> Clinical Supervision focuses on a clinician's knowledge, skills and attitudes and includes: evaluation of competencies, observation of skills, mentoring, planning and monitoring the work of another clinical staff person by a qualified Clinical Supervisor. It includes assuring the quality of treatment, creating a positive work environment and developing staff clinical skills.

For QSUDPT's clinical supervision is required at a minimum of once per month and is a combination of observation, AND individual supervision until they meet requirements of a QP. A QP must be in the room while QSUDPT is providing services until trainee demonstrates competent practice and clinical supervisor documents proficiency in supervision file. At that point the QP is no longer required to be in same room but must be on-site during service delivery.
A QSUDPT must have a job description in their clinical supervision files that states they are a trainee. Trainee status must be made clear to those receiving clinical services.

A QSUDP/Clinical Supervisor must co-sign all documentation done by the QSUDPT.

Note: STUDENTS ENROLLED IN CADC PROGRAMS, MUST HAVE ISAS before working with clients.

Case Management Providers
Agencies offering Case Management (CM) services must ensure they employ qualified CMs, CM Supervisors, and provide CM supervision. CMs qualifications include:

1. a QP per IDAPA 16.07.17 section 200, or
2. a QSUDPT as defined above, or
3. a person with a bachelor's degree or higher in Human Services or related field from a nationally-accredited university or college, or

4. a person with a bachelor's degree plus 2 years of experience working as a case manager in a related field,

Case Management Supervisors must meet the following requirements:

1. Have a master's degree in social services field (unless also providing supervision for clinical staff this person is not required to be a clinical supervisor).
2. Have documented knowledge of working with SUD clientele.
3. Have knowledge of the role of case managers and of community resources.

Case Management Supervision Requirements:
Case managers (CM) must receive a minimum of one (1) hour of case management supervision per month unless the CM is also a clinician who is on a less frequent supervision schedule. CM Supervision must include supervision of case management activities and review of case management documentation. The BPA Health Supervision Manual further details the supervision requirements. It can be found on our website at BPAHealth.com.

Recovery Coach Providers
Agencies providing Recovery Coaching (RC) must ensure RC staff are certified by IBADCC as a Certified Peer Recovery Coach, Certified Recovery Coach, Provisional Certified Peer Recovery Coach, or Provisional Certified Recovery Coach. They must also employ an IBADCC certified Recovery Coach Supervisor and provide RC supervision.

Recovery Coach (RC) Supervision Requirements:
Recovery Coaches (RC), including those with provisional status, must receive a minimum of four (4) hours of supervision per month by an IBADCC Certified Recovery Coach Supervisor. Supervision shall address the four (4) RC domains listed on the IBADCC website and/or the 12 core functions if the RC is also a Qualified Substance Use Disorder Professional Trainee (QSUDPT) working on obtaining Certified Drug and Alcohol Counselor or QP Status. The BPA Health Supervision Manual further details the supervision requirements. It can be found on our website at BPAHealth.com.

Life Skills Facilitator Qualifications
Each Life Skills program must ensure services are provided by qualified staff who meet the following requirements:

1. Each staff person has completed training to deliver the service or has a record of performance in the provision of service.
2. Personnel file must contain documentation that each staff person is qualified.
3. There must be one (1) qualified staff person for every thirty (30) clients in a group setting.
4. The total client caseload of any qualified staff person must not exceed forty-five (45) clients.

Graduate/Undergraduate Student Observation

Undergraduate students who are only observing a few group sessions or shadowing a licensed provider as a part of one of their classes must have a signed confidentiality agreement from the student and the provider must obtain clients' written consent prior to the student observation.

If a student is providing services or accessing client records they are considered a trainee/intern and the provider must follow all guidelines outlined above for trainees.

4.4 Clinical Guidelines and Information

Clinical Practice Guidelines

Clinical practice guidelines offer research-based suggestions to treating a variety of disorders. Practice guidelines differ from treatment guidelines in that practice guidelines are general suggestions for assistance rather than specific treatment requirements. The suggested practice guidelines include an assessment of the strength of the current scientific evidence for each recommendation.

The American Psychology Association offers Clinical Guidelines for Practitioners ranging from record keeping, healthcare delivery systems, to Guidelines for Assessment of and Intervention with Persons with Disabilities. The purpose of these guidelines are to help educate clinicians and give recommendations about professional practices with specific populations without focusing on specific treatments. This is a useful tool for clinicians seeking to develop competencies and/or stay current with new practice areas.

Evidence-based Programs and Practices (EBPs):

Treatment providers are required to utilize EBPS. Providers must submit an EBP Written Description Update Form (located on BPA Health website) for review and approval ***prior*** to implementing any new EBPs as well as when discontinuing an EBP.

Resources for finding evidence-based programs and practices (EBPPs):

1. *Substance Abuse and Mental Health Services Administration (SAMHSA)*, https://www.SAMHSA.gov, offers researched based tips for working with individuals with substance use and mental health disorders.
2. *The Change Company*: http://www.changecompanies.net offers evidence-based programs and trainings on ASAM criteria, motivational interviewing, stages of change and more.
3. *Hazelden:* Addiction Treatment Center: https://www.hazelden.org offers training and evidence-based treatment curriculums.
4. *Institute of Behavioral Research, Texas Christian University*: http://www.ibr.tcu.edu offers evidence-based programming and research in the treatment of substance use and mental health disorders.

Client Records

Client records include assessments, results of drug and alcohol tests, encounters, referrals, mental health screenings and tests, contacts about the client, and any other clinical information that pertains to the care and treatment of the client.

Records are to be prepared, maintained and stored as directed in IDAPA and per BPA Health contract, and signed by the professional providing service. Documentation prepared and signed by a Qualified Professional Trainee must also be reviewed and counter-signed by a Qualified Professional.

Accurate and complete client records will assist providers in delivering the quality healthcare. They will also enable BPA Health to review the quality and suitability of services rendered. To ensure the clients' privacy, client records must be kept in a secure location and in compliance with HIPAA and 42 CFR Part 2 standards.

Client Records Release

Client's treatment and RSS records shall be confidential and not released without the written authorization of the covered person or the covered person's legal guardian. When the release of client records is appropriate the extent of that release should be based upon client necessity or on a need to know basis. Each client record release needs to be documented in compliance with HIPAA and 42 CFR part 2 regulations.

Required Information

Providers must maintain complete client records in accordance with the following standards:

1. Personal/biographical data is present (i.e. employer, home telephone number, spouse, etc.)
2. All entries must be legible
3. All entries must be dated and signed by the clinician (can be electronic)
4. Significant illnesses or client conditions are documented
5. Medication, allergies, and adverse reactions are prominently documented in a uniform location in the client record. If no known allergies exist, that must be documented
6. DHW General Release of Information form
7. Follow-up Survey Informed Consent for all IDHW and IDJC funded clients
8. Documentation that the client was provided education about the importance of HIV and TB testing and referrals to a local testing agency
9. Appropriate subjective and objective information pertinent to the client's presenting complaints is documented in the record
10. Past treatment history is easily identified and includes any psychiatric hospitalizations
11. Working diagnosis is consistent with assessment
12. Risk assessments for suicidal and homicidal ideation
13. Confidentiality of client's information and records is protected
14. An individualized encounter note for each session (group, individual, or family) documenting the content of session, the client's progress towards service plan goals (as evidenced by...), and any specific agreed activities for the client to work on and bring to the next session. Group notes shall reflect use of EBPP.
15. A Service Plan addressing, referring, or deferring (with justification) all identified needs shall be developed within 72 hours of admission to a residential facility and within 30 days of start of treatment in an outpatient program. The service plan must be updated every fourteen (14) days in a residential facility and at least every ninety (90) days in an outpatient setting. (Exception: those in Pre-Treatment or 60 day Parolee Aftercare episodes are not required to have a Service Plan). Service planning is a collaborative process that shall be completed with the client, taking into consideration the client's strengths, needs, and cultural. The plan should include:
    a. Identification of all persons involved in the process including the client and counselor, and when appropriate family and other professionals.
    b. Goals written in simple, measurable, attainable terms with expected achievement dates not to exceed 90 days.
    c. Objectives that relate to the goals, written in simple, measurable, attainable terms with expected achievement dates not to exceed 90 days.

d. Evidence-based interventions to be used for the client's treatment, including frequency of each intervention/service.
e. An outline to include family or other social supports.
f. Referrals/coordination for any needed services not provided by the program including recovery support services.
g. Discharge criteria that is measurable and time specific.

16. If case management services are being billed record must include:
    a. a CM assessment completed within 30 days of first appointment
    b. A CM plan completed within 30 days of first appointment meeting the criteria in #15 – Service plan.
17. A Discharge Summary entered in the client record within 15 days following discharge or 30 days of inactivity. The discharge summary includes the client's status at the beginning of treatment, the progress made in each dimension, the status at the end of treatment, and a summary of referrals or services to be provided after discharge.

Review contract addendums and funding memos for additional information on documentation requirements.

Co-occurring Capability

All treatment providers in the SUD Network are required to be co-occurring capable. All BPA Health treatment providers must complete Co-Occurring Assessment Tool at time of application, renewal, and recredentialing. Providers should contact their Clinical Quality Coordinator to learn more about the required services and assessment process. The Substance Abuse and Mental Health Services Administration offers providers resources on their website at www.SAMHSA.gov.

4.5 Cultural Competency

Within the BPA Health network, Cultural Competency is defined as a set of congruent behaviors, attitudes, and policies that combine to work effectively in cross-cultural situations.

BPA Health is devoted to the development and strengthening of effective and healthy provider/member relationships. Clients have a right to appropriate and quality care. When cultural differences are disregarded clients are at risk for poor quality of care. Clients are less likely to communicate their needs in an indifferent environment, limiting effectiveness of the health care process.
Part of the credentialing and site visit process is to assess the cultural competency level of network providers and provide access to training to help develop cultural competent and culturally proficient practices.
Network Providers must ensure:

1. Clients are informed of their right to an interpreter or TDD services to facilitate communication, provided at no cost;
2. Consideration of the clients' language, ethnicity/race and its influence of the clients' health
3. Culturally competent office staff that routinely come in contact with clients participate in ongoing cultural competency training and development;
4. Administrative staff attempts to collect race and language specific client information;
5. Service plans take into consideration race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process;
6. Office sites have posted and printed materials in English, Spanish, and other prevailing languages within the regions.

Understanding the Need for Culturally Competent Services

Research shows that a person has better health outcomes when they experience culturally appropriate interactions with providers. Developing cultural competency begins with self-awareness and acceptance that cultural competency is ongoing. The experience of a client begins at the front door. Failing in being culturally and linguistically competent could cause the following results for clients:

1. Feelings of being insulted
2. Reluctance and fear of making future contact with the office
3. Misunderstanding and confusion
4. Non-compliance
5. Feelings of being uncared for, looked down on and devalued
6. Parents' resisting to seek help for their children
7. Missed appointments
8. Provider's misdiagnosis
9. Increased grievances or complaints

Preparing Cultural Competency Development

BPA Health encourages the recognition and acceptance of the value of meeting the needs of your clients.

Here are some questions to keep in mind as you provide care to clients:

1. How are cultural differences impacting your relationship with your clients?
2. What do you know about your client's culture and language?
3. Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
4. What are your own cultural values and identity?

For more information on CLAS, please see the following link: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf

Cultural Competency Training

BPA Health encourages providers to continuously train their staff on cultural competency. Our trainers will also ensure that all trainings include cultural competency objectives to increase participants' understanding, appreciation, acceptance, and respect for cultural differences and similarities. BPA Health is committed to the development, strengthening, and sustaining of healthy provider-client relationships that reflect cultural competence in the services provided by both the provider network and BPA Health staff. We believe that a client has a better outcome when they experience culturally appropriate interactions with treatment and RSS providers.

4.6 Utilization Management Program

Purpose

BPA Health's Utilization Management (UM) Program provides a structure and process by which clinical appropriateness and effectiveness of behavioral health services are defined, continuously monitored, and improved over time. The purpose of the UM program is to provide easy and equitable access to quality behavioral health services, which focus on individualized treatment strategies that promote the principles of recovery and resiliency to consumers seeking substance use disorder treatment. The BPA Health UM program is designed to evaluate the quality, cost, and the coordination of services provided to our consumers. BPA Health strives to build strong, working relationships with our network and community-based providers to improve the delivery of services.

Goals

The purpose of utilization management is to create a system that facilitates necessary communication with the providers serving our consumers in order to produce efficiency in the authorization process and access to services. The UM program assures appropriate utilization, which includes evaluation of potential overutilization, underutilization and timely access to services, and identifies opportunities for improvement in utilization patterns. Review of services is based on medical necessity in accordance to BPA Health's Clinical Review Criteria policies and standard operating procedures.

The following are the goals of the Utilization Management (UM) Program:

1. Assure services rendered are medically necessary and furnished in an amount, duration and scope that address the needs of the consumer using written, objective clinical review criteria based upon professionally recognized resources and established with input from clinical staff members and substance use disorder professionals.
2. Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity according to the Prospective, Concurrent, and Retrospective Review Policy.
3. Establish the process used to review and approve the provision of behavioral health services, including an appeal system for non-certifications including eligibility and service denials, reduction in services, or termination of services.
4. Enable members to access approved behavioral health services in a timely manner.
5. Notify members and/or providers of UM decisions in a timely manner.
6. Establish accountability structures and processes for communication and integration of a comprehensive plan across providers, settings, and the continuum of care.
7. Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and with applicable state and federal laws that govern the utilization management process.
8. Protect the confidentiality of consumer and provider information and records.
9. Explore opportunities to create and innovate in health care management, recovery oriented systems of care, and service delivery with consumers and providers.

Guiding Principles and Methodology

In order to solidify our commitment to quality healthcare, the BPA Health UM Program has received full URAC accreditation and adheres to both the Version 3.0 CORE and 7.3 Health Utilization Management (HUM) Accreditation Standards. Because BPA Health believes quality is an organizational value synonymous with performance, the UM Program is based on a responsibility to consumer driven services, our provider network, and continuous quality improvement (CQI). UM is highly integrated with the Quality Management Program, which continuously monitors program data, evaluates clinical and consumer satisfaction results, and takes focused actions when opportunities for improvement are identified.

Clinical Review Criteria

BPA Health has approved the American Society of Addiction Medicine (ASAM) criteria for our UM Program clinical review criteria. The criteria facilitates the pairing of individuals living with substance use disorders with the services and tools they need for a successful and long-term recovery. ASAM empowers service providers to create client-centered service plans and to make objective decisions regarding level of care placement, movement throughout the care continuum, and co-occurring condition needs for a variety of populations in a wide range of care settings.

Clinical review criteria are used to ensure that all care management decisions:

1. Are made in a standardized and consistent manner.
2. Will determine the most appropriate and medically necessary care available.
3. Meet the needs for safety, health, and general wellbeing of the populations we serve.
4. Are based in scientific literature pertaining to established clinical guidelines and organizational practices, both locally and nationally, and
5. Will have regular oversight and reexamination by the BPA Health staff.

These criteria are reviewed annually both internally and externally, to ensure that our assessment and determination tools are based on the latest scientific evidence and professional standards. The Care Management team is trained on the chosen clinical review criteria. During the course of day-to-day utilization management activities, UM staff will have readily available access to the appropriate criteria and clinical oversight for reference in clinical decision-making.

Staff Roles and Responsibilities

The Care Management Operations Supervisor and Customer Support Supervisor oversee the day-to-day activities of the utilization management program. The UM Department utilizes non-clinical and clinical staff members. UM staff performs functions that ensure consumers get the right care at the right time based on the applicable benefit eligibility structure. This includes care coordination activities for individuals identified as high risk to promote their safe transition between providers and care settings.

Client Intake Specialists are non-clinical staff that are trained to review service requests for completeness of information, collection and transfer of non-clinical data, conducting initial screening to determine benefit eligibility, triage of crisis calls, processing documents from providers, consumers, and referral sources, placing initial assessment authorizations, and creating or modifying authorizations based on current processes. They do not conduct any utilization management activities that require interpretation of clinical information or

clinical decision-making. Licensed health professionals are available to non-clinical staff at all times. Client Intake Specialists are responsible for engaging and working with Care Management staff for oversight and follow up when there are questions of a clinical nature or when there is a crisis situation requiring immediate clinical intervention.

Care Managers that conduct initial clinical reviews must at least possess:

1. A bachelor's degree in a behavioral health related field, and
2. May also hold an active, professional license or certificate to practice as a health professional in a state or territory of the United States and within a scope of practice that is relevant to the clinical area(s) addressed in the initial clinical review.

Care Managers have access to peer clinical review staff at or above the education/licensure level of themselves and/or the provider, including access to the Clinical and Medical Directors. Requests of clinical nature will be peer reviewed prior to issuing a decision of non-certification for a clinical reason.

Care Managers who conduct peer clinical reviews have:

1. A master's degree in an area related to behavioral health
2. Hold an active, unrestricted license or certification to practice medicine or a health profession in Idaho and are qualified as determined by the Clinical or Medical Director to render a clinical opinion about the procedures and treatment under review.
3. Peer reviewers must hold a current and valid license/certification in the same licensure/certification category as the ordering provider;
    a. or as a doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.). M.D.'s and D.O.'s may review care recommended by any type of practitioner, but only M.D.'s and D.O.'s may review other M.D.'s and D.O.'s.

The Medical Director makes non-certification determinations based on medical necessity for services involving urgent care and residential treatment, in accordance with BPA Health policy. If initial clinical review indicates a potential medical necessity issue or quality of care concern, the care request will be referred to an appropriate clinical peer reviewer.

UM Decision-Making

BPA Health will base determinations on the clinical information obtained at the time of the ASAM review and will accept information from any reasonably reliable source that will assist in the certification process. Retrospective reviews will be conducted when needed upon receipt of all pertinent clinical and claims information in writing and determinations are based on the clinical

information available to the provider at the time the service was provided. When conducting a routine review, BPA Health collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services. We require the GAIN assessment with SUD DSM diagnostic code/ diagnosis and an ASAM update to certify medical necessity or appropriateness of the admission, extension of stay, frequency or duration of service unless an exception has been made by IDHW through the waiver process.

BPA Health staff uses the WITS Electronic Health System as a means to share all clinical and demographic information on individual clients among its various clinical and administrative departments that have a need to know, in order to avoid duplicate requests for information from clients and providers. Information obtained during UM decision making process is confidential and will be managed in accordance with BPA Health policy.

BPA Health does not delegate the UM function.

4.7 Provider Audits

After a provider has completed contracting and initial WITS trainings, BPA Health will conduct a new provider orientation. This orientation will familiarize providers with required documentation and BPA Health audit tools.

Three to four months after the first billed services, providers will undergo an Initial Compliance and Training audit to establish a baseline understanding and application of network requirements. The results of this review are not reported to IDHW or any other Partner.

Types of Audits:

1. Quality, Effectiveness and Compliance (QEC) Audit:
   a. Assesses the quality and effectiveness of treatment, and compliance with IDAPA, BPA Health, and professional standards by conducting a thorough review of client and agency records.
2. Supervision Audit:
   a. Review of clinical, case management, and recovery coach supervision records, monitoring for adherence to BPA Health Supervision Manual.
3. Evidence-based Programs & Practices (EBP) Audits:
   a. Review of the programs and practices used by providers to implement SUD treatment services.
4. Facility Renewal Audits:

a. Review renewal application and conducti facility walk-through to ensure safety and compliance.

Scheduled Audits

BPA Health offers the following tiered audit schedule for QEC and Supervision Audits. EBP audits of treatment providers are conducted every 6 months. SSH and transitional living providers who score 90% or better on QEC audits two consecutive years may be placed on a two-year auditing timeline for reviewing charts. However, facility walk-throughs – which include fire drill and inspection records must be conducted annually in all cases.

Score of QEC and Supervision Audits	Audit Frequency at a **Minimum***
90% and above 2 consecutive years	Every 2 years
80% and above	Annually
79% and below	Quarterly

* Audits may be scheduled more frequently if compliance or quality of care concerns exist or if agency has experienced turnover. EBP Audits are scheduled every 6 months regardless of score.

In the event of a score less than 80% the provider will be required to submit a Corrective Action Plan within 10 days upon receipt of the audit results. When the Corrective Action Plan is then approved by the Clinical Quality Coordinator, the deadline for the next audit is set for approximately 120 days out. EBP audits are conducted twice a year.

If BPA Health identifies a consistent deficiency and the score is above 80% a Performance Improvement Plan (PIP) is requested and due for approval 10 days upon receipt of the request. The Performance Improvement Plan is then sent to BPA Health for approval and the Provider remains on the annual timeline.

If a provider has had no SUD clients at the time of annual/biennially audit they will be required to complete the WITS and BPA Health New Provider trainings again to ensure continued understanding of processes and requirements in order to remain active in the SUD Provider Network.

Audit timelines are ultimately at the discretion of BPA Health. Any exception to the above periods will be communicated at the time of receipt of audit results.

CARF and JACHO
CARF and JACHO accredited SUD facilities will not be audited while their accreditations are in good standing.

Out of State Providers
Providers in other states may be contracted when the treatment needs of state funded clients are not met by Idaho treatment providers. In these cases, BPA Health defers audits and EBP review to the local state certifying agency. BPA Health may require Performance Improvement, or Corrective Action plans from provider, even if their audits are complete by another governing agency.

For-Cause Audits
If BPA Health receives a complaint or identifies a problem or potential problem with any provider regardless of the scheduled audit plan, BPA Health may determine an audit is necessary to ensure compliance. For-cause audits may occur with no advance notification.

Audit Scheduling and Procedure
Audits are scheduled the month prior to the deadline. BPA Health will make every effort to schedule audits at the provider's convenience prior to the deadline. To fulfill our contractual obligations to IDHW we cannot schedule audits past the deadline.

Once the audit is complete BPA Health will review the findings of the audit and forward to the provider. In each region a Clinical Quality Coordinator is available to schedule technical assistance training.

Independent Peer Review
SUD Providers must understand and agree to participate in Independent Peer Review in accordance with 42 USC 300x-53.(a)).

4.8 Quality Assurance Program

BPA Health is committed to providing quality programs and services to our clients, families, and customers. As such, we place great emphasis on the quality of our provider networks. BPA Health considers each network provider to be an integral part of the Quality Management Program and expects each provider to participate in BPA Health's Provider Quality Assurance Plan.

The Provider Quality Assurance Plan sets forth BPA Health's provider network quality standards along all lines of business to ensure clients are receiving high quality care and providers' treatment environment and operations.

BPA Health's provider performance standards are assessed, monitored and maintained through the following quality monitoring activities:

1. Provider credentialing and recredentialing
2. Quality of care concerns
3. Site visits
4. Satisfaction surveys
5. Corrective action plan compliance
6. Terminations and sanctions monitoring
7. Withhold Performance Requirements
8. Recurring provider reports

Primary Activities

The Quality, Evaluation, and Training (QET) Department oversees the daily operations of the provider quality assurance activities. These activities include the following:

1. Overseeing the monitoring functions;
2. Tracking and trending key indicators of:
   a. Provider compliance with plan
   b. Internal quality compliance to plan and adherence to nationally recognized criteria.
3. Ensuring ongoing use of quality review information in making credentialing and recredentialing decisions.
4. Ensuring that appropriate training, resources and support are provided to providers and throughout the organization to achieve quality goals.

Primary Monitoring Activities

The BPA Health Provider Quality Assurance Plan includes the following primary monitoring activities:

1. Provider credentialing and recredentialing: The Provider Quality Assurance Plan monitors and assesses provider credentialing and recredentialing criteria and ensures BPA Health internal quality metrics comply with national standards.
2. BPA Health credentials providers within our networks based on criteria that reflect professional and community standards as well as applicable laws and regulations. All providers and/or agencies are required to participate in the credentialing process as the basis for ensuring BPA Health's providers meet our quality standards.
3. The recredentialing process is a provider quality-monitoring program that includes gathering pertinent data from client concerns, complaints on site review results, treatment record review results, quality of care issues, and quality improvement activities. In addition, BPA Health conducts ongoing monitoring of provider sanctions, complaints and quality issues. When issues

are identified, BPA Health adheres to the provisions as outlined in the Provider Termination & Sanctioning Policy.

4. Quality of Care Concerns:
   a. The Provider Quality Assurance Plan monitors appeals, complaints and adverse incident data to ensure consistent quality of service to our clients. Pertinent data is reported to the appropriate quality committee per BPA Health policies.
5. Site Visits:
   a. The Provider Quality Assurance Plan ensures BPA Health meets national quality accreditation standards for conducting on-site reviews of all BPA Health's network providers. The site visits are conducted in accordance with BPA Health policy.
6. Satisfaction Surveys:
   a. Satisfaction surveys are utilized as a way to gather client and provider feedback regarding quality concerns. Data from the survey may trigger a complaint or fraud/waste/abuse investigation.
7. Corrective Action Plan Compliance
   a. A Corrective Action Plan (CAP) is utilized as a mechanism to engage the provider in a performance improvement process as outlined in the Corrective Action Plan Policy.
8. Terminations and Sanctions Monitoring:
   a. A provider can be denied credentialing/recredentialing, sanctioned, or terminated from providing services to BPA Health clients in accordance with the Provider Termination & Sanctioning Policy.
9. Withhold Performance Requirements:
   a. A withhold of 5% of the DHW and IDOC clinical and RSS billing is made to encourage compliance in meeting specific operational targets determined by the funding partners. Provider compliance is evaluated quarterly, and upon meeting these requirements the withhold amount is paid to the provider.
   b. Withhold performance metrics are reviewed throughout the year. Current metrics can be found on the BPA Health website.
   c. Providers unable to maintain these elements or struggling with other clinical activities may be placed on a performance improvement plan and may be required to attend mandatory WITS trainings to bring their agency into long term compliance. In addition, these requirements will be integrated into a review of overall provider quality for Credentialing Committee consideration of administrative competence.
   d. MAT bundled services will be reimbursed the full 5% withhold during the quarterly withhold process.
10. Recurring provider reports:
   a. Providers will receive provider specific reports based on quality metrics so providers are aware of how they are being measured and their results.

4.9 Non-discrimination Requirement

1. All Providers must have and implement non-discrimination policies in hiring and service provisions using language consistent with the following:

    a. Programs and activities receiving federal financial assistance, including programs funded in whole or in part by the MHBG or the SABG, must have prohibitions against discrimination on the basis of the following: (1) age under the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.]; (2) handicap under section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794]; (3) sex under title IX of the Education Amendments of 1972 [20 U.S.C. 1681 et seq.]; or (4) race, color, or national origin under title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.].

    b. No person shall on the ground of sex (including, in the case of a woman, on the ground that the woman is pregnant), or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available through the MHBG or SABG.

4.10 Debarment and Suspension

1. Government-Wide Debarment and Suspension (Nonprocurement) [13 CFR 400.109] SUD participating providers agree to participate in the government-wide exclusion of suspended or debarred personnel and has policies to that effect.

4.11 Partner-Specific Requirements/Information

State partners have specific requirements for populations being served. Those requirements can be found in the resources section on the BPA Health website.

4.12 Tele-Behavioral Health (TBH)

BPA Health must approve providers who wish to use Tele-Behavioral Health to provide SUD services prior to starting services. To be approved, Providers must submit a plan to Provider Relations that addresses the following concerns:

1. Must have a HIPAA Compliant video conference platform.
2. How telehealth consents will be collected from clients.
3. How to assist the client in case of an emergency.
4. How the agency will protect client privacy i.e. use of ear buds, private setting.

TBH Provider Responsibilities include:

1. Establish a Provider-Client relationship
2. Determine the appropriateness of the client
3. Ensure telehealth does not interfere with therapy

Once BPA Health receives the agency's plan, a telehealth screening will be scheduled with the Provider to troubleshoot any technical difficulties and discuss important aspects of tele-behavioral health prior to the agency's approval.

Once approved, Providers will not need a special authorization. However, they must select "telehealth" as the service location.

5. BPA Health Obligations and Responsibilities

1. BPA Health is responsible for all determinations as to the eligibility of any member for Covered Services under the Provider Agreement. BPA Health shall notify Providers of the authorization for services to be provided under the Provider Agreement. *Reference section 3.1 of the Provider Agreement*.
2. BPA Health shall perform the necessary administrative functions, including clinical review as appropriate for this contract. *Reference section 3.2 of the Provider Agreement.*
3. BPA Health shall have the final decision-making authority with regard to the determination of whether a particular service is a Covered Service and whether particular service is an Authorized Service under the terms of the Provider Agreement. *Reference section 3.3 of the Provider Agreement.*
4. BPA Health shall allow Provider the opportunity to elect not to participate in any health care service plan or insurance programs for which it is contractually obligated to arrange for the provision of behavioral health care. *Reference section 3.4 of the Provider Agreement.*

6. Representations

1. BPA Health warrants and represents that it is a corporation registered with the Idaho Secretary of State's office. *Reference section 4.1 of the Provider Agreement.*
2. Provider hereby warrants and represents that all staff have appropriate licensure, certification or background education for the services they provide. *Reference section 4.2 of the Provider Agreement.*
3. Provider agrees that all services for which claims are submitted are delivered in facilities licensed or approved by the State and/or BPA Health. *Reference section 4.3 of the Provider Agreement.*

7. Compensation and Penalties

1. BPA Health or contracted insurer shall pay Provider for Covered Services rendered that were pre-authorized by BPA Health for an Eligible Member, minus the applicable co-pay, in accordance with the provisions of the Provider Agreement. Fee schedule(s) and special compensation procedures are attached to the Provider Agreement on a per contract basis. See Exhibit A for specific fee schedules. *Reference section 5.1 of the Provider Agreement.*
2. Provider shall bill for all Covered Services rendered that were pre-authorized. All billings must be submitted within 30 days of the dates of service. All billings must be submitted in accordance with BPA Health billing *Reference section 5.2 of the Provider Agreement.*
3. Provider agrees to bill only for services provided directly by the authorized Provider. *Reference section 5.3 of the Provider Agreement.*
4. Provider may charge, and collect directly from a Non-Eligible persons for services rendered to the individual, where BPA Health determines that the individual did not meet membership criteria at the time of service. Provider shall not look to BPA Health for payment for services rendered to non-eligible persons, services which were not preauthorized by BPA Health, or for services the individual is not eligible to receive under the particular State funded program. These services may be charged to, and collected from the individual only if the person has requested such services. *Reference section 5.4 of the Provider Agreement.*
5. Provider shall not balance bill Eligible Members for charges beyond those covered by the applicable contract. Provider shall seek payment for the Covered Services rendered under the terms of the Provider agreement from BPA Health or the contracted insurer and not from Eligible Members, except for authorized co-payments and deductibles. *Reference section 5.5 of the Provider Agreement.*
6. Within thirty (30) days of receipt of a clean claim, which includes all necessary information, BPA Health shall pay to Provider the balance of billed charges per the appropriate fee schedule, less applicable co-payments, penalties and deductibles, in accordance with the terms of the Provider Agreement and the appropriate benefit plan. *Reference section 5.6 of the Provider Agreement.*
7. The Provider Agreement allows open provider-patient communication regarding appropriate treatment alternatives without penalizing providers for discussing medically necessary or appropriate care for the patient. *Reference section 5.7 of the Provider Agreement.*

8. Provider shall not bill or seek to collect from BPA Health or the Eligible Member any reimbursement or payment for any amount for Covered Services other than member's co-pay during unauthorized periods. *Reference section 5.8 of the Provider Agreement.*
9. Except as otherwise provided in Paragraph 5.4 herein, Provider shall bill and collect all authorized co-payments and deductibles, non-covered services and unauthorized services directly from the Eligible Member. BPA Health agrees to provide Provider with adequate information concerning Member's authorized deductibles and co-payments. *Reference section 5.9 of the Provider Agreement.*
10. BPA Health, at its sole discretion, may withhold up to 5% of the aforementioned fee as an incentive to ensure Provider is meeting its contractual requirements. BPA Health agrees to pay the withheld incentive on a quarterly basis to Providers who have remained contractually compliant through the quarter. *Reference section 5.10 of the Provider Agreement.*
11. BPA Health may recoup unsubstantiated claims, billing outside of rate matrix without justification, billing for non-billable activities, treatment notes missing QP signature, services provided by an unqualified person, or other billing errors discovered during review of documentation. Providers will be notified of any claims recoupments.

8. Coordination of Benefits

8.1 Referrals and Funding Sources

Funding for Substance Use Disorder Services is appropriated from the Idaho State Legislature to the following: Idaho Department of Health and Welfare, Idaho Department of Corrections, Idaho Department of Juvenile Corrections and the Idaho Supreme Court. Each has their own budget and specific guidelines for referrals and treatment.

BPA Health's primary role is to credential and manage the performance of a Statewide Substance Use Disorder Network that can be used by the four entities. BPA Health manages clients, utilization and claims payment for only certain populations. Here is a summary of who conducts oversight based on the state funding source:

SUD Services					
	Network Management	Eligibility Screening	Initial Authorization	Continued Stay Review	Claims
IDHW	BPA	BPA	BPA	BPA	BPA
IDOC	BPA	IDOC	IDOC	BPA	BPA
IDJC	BPA	IDJC	IDJC	IDJC	IDJC
Courts	BPA	Courts	Courts	Courts	Courts

8.2 SUD System Services

Treatment and Recovery Support Services that are covered for eligible populations and allowable for state-funded reimbursement are described in IDAPA and detailed on each entity's SUD Rate Matrix located on the BPA Health website.

Treatment Services:

The following descriptions are based on ASAM Levels of Care. More detailed information on each level of care is included in the book, ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions / Edition 3.

Qualifications for individuals providing treatment services:

The clinical staff at the provider agency must meet conditions of a:

1. Qualified SUD Professional per IDAPA 16.07.17 section 200, or
2. Qualified SUD Trainee (QSUDPT) per IDAPA 16.07.17 section 210 AND who meets the following additional BPA Health Standards.
   a. Formal documentation as Certified Idaho Student in Addiction Studies (ISAS); or
   b. Formal documentation as a Northwest Indian Alcohol/Drug Specialist Counselor I; or
   c. Formal documentation of current enrollment in an accredited program in accordance with the qualifications of IDAPA 16.07.17 IDAPA Section 200of these rules.

      Note: *STUDENTS ENROLLED IN CADC PROGRAMS, MUST HAVE ISAS before working with clients*.
3. An individual who has completed a program listed in IDAPA16.06.17 Section 200 and is awaiting licensure can continue to be recognized as a QSUDPT at the same agency for a period of six (6) months from date of program completion. Individuals may not be a trainee for a period of more than three (3) years.

Assessment

All approved programs must utilize the GAIN assessment tool as approved by the Idaho Department of Health and Welfare, unless noted by funding requirements. A Qualified Professional Trainee can conduct an assessment with the appropriate Qualified Professional oversight (see section for Supervision for Trainees). The Qualified Professional must cosign the assessment.

The GAIN must be appropriately consented in WITS to complete the assessment process. The consent must be dated the date the GAIN was completed or prior. Ensure "yes" is marked in the section that asks if the client has signed the paper agreement form and have the agreement form in the file. The Partners may require other or additional assessments separate from the GAIN. Providers are required to use the assessments mandated by the Partners.

Level I Outpatient Treatment

Called Outpatient Services for adolescents and adults, this level of care typically consists of less than 9 hours of service/week for adults, or less than 6 hours a week for adolescents for recovery or motivational enhancement therapies and strategies. Level 1 encompasses organized services that may be delivered in a wide variety of settings.

Level 2.1 Intensive Outpatient / Partial Hospitalization

Called Intensive Outpatient Services for adolescents and adults, this level of care typically consists of 9 or more hours of service a week or 6 or more hours for adults and adolescents respectively to treat multidimensional instability. Level 2 encompasses services that are capable of meeting the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening, and/or on weekends.

Medication Assisted Treatment (MAT)

Medication used in conjunction with Level 1 or Level 2.1 treatment services to treat opiate use disorders. Treatment providers must be in the IROC network and work with a Data Waiver 2000 prescriber to qualify to receive referrals for IROC/MAT funded services.

Level 3.1 Clinically Managed Low-Intensity Residential Services (Adolescent Transitional/Adult Halfway House)

The ASAM Criteria, Third Edition 2013, indicates, "An example of a Level 3.1 program is a halfway house, group home, or other supportive living environment with 24-hour staff and close integration with clinical services… Level 3.1 is not intended to describe or include sober houses, boarding houses, or group homes where treatment services are not provided."

ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services provides residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services. Level 3.1 includes a clinical services component and a recovery residence component. The clinical component includes low-intensity treatment services of at least 5 hours per week which may include individual, group and family therapy and may be provided on-site or arrange to be provided by and coordinated with another outpatient program.

Level 3.1 facilities are structured recovery residence environments that provide sufficient stability to prevent/minimize relapse or continued use. They provide an emphasis on community, social bonding and cohesion among recovery persons. These facilities provide 24-hour on-site staff to monitor and provide structure for residents. Staff are required to have background and experience working within the substance use disorder and/or mental health field. The clinical staff and facility services must be overseen by a Qualified Professional (QP) who is available on site or by phone at all times.

Facilities that choose to provide prepared meals are required to have a health inspection and Food Service Permit. If facility requires clients to prepare their own meals, the facility must have standard working kitchen equipment, and follow any state Health District guidelines. Each client must have a designated food storage area and refrigeration space.

Adolescent Level 3.1 also requires the Provider to be licensed under the "Child Care Licensing Act," Title 39, Chapter 12, Idaho Code, according to IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." Staff working in adolescent programs must be knowledgeable in adolescent development and experienced in engaging and working with adolescents.

Level 3.5 Residential

Called Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults, this level of care provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Patients in this level are able to tolerate and use full active milieu or therapeutic communities. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

Level 3.5 treatment facilities must provide individual and group counseling activities, family treatment services, and substance use disorders education. This

Clinical Care must include at least twenty-one (21) hours a week of clinical treatment programing for adolescents. For adults, in addition to the requirements for therapeutic milieu, at least 30 hours of clinical treatment program hours are required. A minimum of 6 hours of structured non-clinical hours of recovery activities are required as part of this therapeutic milieu. The therapeutic milieu and clinical involvement can be expected to encompass the entirety of each day for the resident/participant. The program will evidence the therapeutic milieu through its schedule of recreation and appropriate activities available to all clients during the day, evenings and on weekends. The activities must be planned to provide a consistent and well structured, flexible framework for daily living and practicing the skills being learned. Participants must be involved, whenever possible, in planning activities.

Recovery Support Services

Recovery Support Services (RSS) promote client engagement in the recovery process and provide services needed for support of a client's continued recovery. Recovery support services are initiated with the client at the earliest possible point in the individual planning and service delivery process. Ideally, RSS are identified at the outset of treatment as part of the development of the individual treatment plan. It is expected that the client's needs will change during course of treatment so recovery support is an ever-evolving plan. Organizations collaborating in order to provide RSS are expected to maintain linkages with the primary service provider in order to fully assess the effectiveness of on-going services and to determine if additional services are needed.
State-Funded Recovery Support Services include:

1. Case Management – Basic and Intensive
2. Safe & Sober Housing
3. Alcohol & Drug Testing
4. Transportation
5. Life Skills
6. Child Care
7. Recovery Coaching

NOTE: ALL IDAPA applicable SUD standards for policies and procedures must be met.

Case Management

Case Management services are assessing, planning, linking, coordinating, monitoring, and advocating for clients and their families to ensure that multiple services, designed to ensure their needs for care, are delivered in a coordinated and therapeutic manner to meet the goals of treatment outcomes.

Covered services and functions:

a. Advocacy

b. Assessment
c. Coordination of Services: Coordination provides a linkage across all services and support systems and provides for needed and timely transitions between levels of care, services, and service providers. This coordination can be face-to-face or via telephone.
d. Linking the Client to Needed Services: "Linking" includes finding, arranging and assisting the client to gain benefit from access to and maintenance of services, supports, and community resources identified in the Comprehensive Service Plan.
e. Monitoring client progress and staffing with other professionals (e.g. POs, clinicians, etc.).
f. Planning
g. Assisting in completing paperwork associated with obtaining needed services (e.g. food stamps) when the client or client's family are present.

Note: Reimbursement is not allowed for missed appointment, attempted contacts, travel to provide the service, leaving messages, transporting clients, or documenting services. Additionally, case management activities must be documented in the care plan in order to be billed.

A written comprehensive case management service plan is to be completed within 30 days of the first client visit and to be updated at least every 90 days thereafter. The plan must addresses the needs of the client as identified through the assessment process. The plan development is to be a collaborative process involving the client and other support and service systems. It must include information from the assessment of client strengths and needs. A comprehensive plan includes current medical needs, legal needs, financial, transportation concerns, mental health issues, housing status, job potentials, client strengths and limitations, family concerns that may impact the client and other areas that may influence the client's success with completing treatment and being successful in the community.

While assisting a client, phone calls or other contacts may be of short duration. Each day's billable times may be included into one note for the total time, provided the note delineates the times for each activity.
Reimbursable services include: face-to-face contact with client, client's family, legal representative, primary caregivers, service providers or others directly involved with the client's recovery; telephone or email contact with the individuals listed above; paperwork completed to obtain services (client must be present); and updating Probation and Parole on client participation and progress.
If a provider is billing for case management services, there must be documentation of at least one face-to-face session every 30 days.

Recovery Coaching

A Recovery Coach is a personal guide and mentor for people seeking or in recovery. Recovery Coaches help to remove barriers and obstacles and link the recovering person to the recovery community. They serve as a mentor, ally, role model, motivator, problem solver, resource broker, advocate, and community organizer.

Recovery Coaches shall complete a Recovery Wellness Plan with client within in 30 days of the first Recovery Coach appointment.

Life Skills (LS)

Life Skills programs are designed to enhance personal and family skills for work and home, reduce marriage/family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community.

The goal of Life Skills services is that through advocacy, teaching, role modeling, educational, social service and groups, clients and consumers in recovery will find and adopt the various tools they will need to become productive members of society. Life Skills activities may include activities that are culturally, spiritually or gender specific.

Below is a list of approved subjects for Life Skills programs. This list provides examples of possible topics that may be addressed as well as online resources for building a curriculum. This is only a guideline and providers may address additional topics as long as they are related to the list of approved curriculum subjects**.** Life Skills activities for recovering individuals may be provided on an individual basis or in a group setting and shall consist of one or more of the following objectives:

1. *Money Management* - Budgeting and savings, balancing a checkbook/checking account, improving/fixing credit issues.
2. *Employability Skills* - Resume formats and content, filling out a job application, interviewing skills.
3. *Healthy Relationships* - Family relationships, marital/romantic relationships, friends/co-worker relationships, communication skills.
4. *Nutrition and Cooking* - Outline of a balanced diet, how to read and understand food labels, how unhealthy foods affect the body, meal planning, food shopping/creating a grocery list.
5. *Stress and Anger Management* - Relaxation techniques, coping skills, involvement in leisure activities.
6. *Parenting Skills* - Understanding basic child development, methods of disciplining children, how substance abuse affects parenting skills.

7. *Adolescent Independent Living Skills* - Apartment hunting, managing finances and paying bills, employability skills, applying for financial assistance/college loans, meal planning and food shopping.
8. *Pastoral Counseling* - Recognizing addiction, how substance abuse affects families and communities, the role of a "higher power" or religion in recovery, appropriate pastoral roles and interventions.

Any provider wanting to provide Life Skills for any of these approved subjects must submit to BPA Health a basic curriculum outlining topics that will be addressed. Additional information and materials may be requested in addition to the curriculum

Life Skills programs must have a written plan. This written plan must include the curriculum/outline to be used. The list of activities must include:
1. A description of each activity;
2. The measurable goals of each activity;
3. The staff person responsible for providing or supervising each activity.

Life Skills may be approved for clinical treatment providers on a case-by-case basis under the following conditions:
1. The service is billable only as a recovery support service.
2. The service is distinguishable from treatment services.

Safe & Sober Housing and Enhanced Safe & Sober Housing

Safe and Sober Housing (SSH) programs provide a safe, clean and sober environment for adults with substance use disorders who are transitioning back into the community.

Staffed Safe and Sober Housing facilities may include either or both of the following:
1. Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living is typically provided for 3-6 months and can be offered in congregate settings that may be larger than residences typically found in the community.
2. Long-term housing that provides stable, supported community living or assists the client in obtaining and maintaining safe, affordable, accessible, and stable housing.

Statutes regulating transitional housing can be found at 42 U.S. Code 11384 (b) and implemented at 24 CFR 583. Statutes for Safe and Sober Housing can be found in the federal Anti-Drug Abuse Act of 1988.

Safe and Sober Housing programs afford the following community living components:

1. Regular meetings between the staff and clients.
2. Opportunities to participate in typical home activities.
3. Linkage to healthcare when these needs are identified.
4. Daily access to nutritious meals and snacks.
5. Opportunity of choice by the persons served as to room and housemates.
6. Opportunities to access community activities including but not limited to: cultural activities, social activities, recreational activities, spiritual activities, self-help groups, and necessary transportation.

To ensure safe environment that promotes recovery all Safe and Sober Housing programs shall:

1. Ensure a list of Community Resources are posted in a visible location and available to clients 24/7.
2. Conduct weekly inspections to determine if any hazards or potential safety issues exist. A record of the inspections must be maintained that includes the date and time of the inspection, problems encountered, and recommendation for improvement.
3. Conduct and document at least one (1) fire drill every thirty (30) days at unexpected times and under varying conditions to simulate unusual circumstances encountered in case of a fire. Documentation must include the date and time of the drill, and if problems were encountered the recommendations for improvements.
4. The size of rooms are capable of safely housing the number of clients; the facility and outdoor areas are neat, clean and welcoming; and the facility and outdoor areas are free from safety hazards.

Safe and Sober Housing programs shall not bill rent to clients receiving State Substance Use Disorder funding for housing but may impose a "program fee" to cover the following expenses:

1. Basic Utilities—electricity, gas, water, sewer, trash, etc.
2. Telephone Service
3. Cable/Satellite T.V.
4. Internet services (if available to client)
5. Amenities Fund—Covers wear and tear on home living items such as furniture, bedding, curtains, washer and dryer, cookware, dishes, appliances, etc.
6. Cleaning supplies (if supplied by provider)

Program fees must not exceed one hundred dollars ($100) per month. Program fees must be imposed equally on residents receiving state funding for housing and non-state funded residents. Adult Staffed Safe and Sober Housing facilities must assure that clients fully understand the purpose of an imposed program fee and what it includes.

Enhanced Safe and Sober Housing (ESSH) programs are staffed 24/7 with clinical oversight and care coordination of a QP. Referrals to Enhanced safe and Sober Housing come from State Hospital.

Termination of Housing from an Adult Staffed Safe and Sober Housing Facility. The housing provider may discharge a client who violates house rules and requirements in accordance with the following:

1. Client is informed verbally and in writing of reasons for discharge.
2. A process is in place that recognizes the rights of the client to due process and allows the client to request a formal review of the decision;
3. The reasons for discharge and any actions following are clearly documented in the client's file.

Drug Testing

Alcohol and drug testing results are objective measures of treatment effectiveness, as well as a source of important information for periodic review of treatment progress. Alcohol and drug testing helps support positive treatment outcomes and provides accurate and reliable data supportive of other data collection efforts.

An accurate testing program is the most objective and efficient way to establish a framework for accountability and to gauge each client's progress. Methods of testing may include the use of urine specimens or oral swabs. See Resource Memos on BPA Health website for any Partner specific requirements. In addition to the general requirements for RSS providers outlined in IDAPA, alcohol and drug testing programs must meet the following requirements:

1. Drug testing results must be shared with referrals source(s) after obtaining an appropriate ROI (e.g. treatment provider agency, Probation and Parole, case worker).
2. Alcohol and drug testing policies and procedures are based on established and tested guidelines. Licensed contracted laboratories analyzing urine or other samples are also to be held to established standards.
3. Testing will be provided at the provider location and may be administrated randomly or at scheduled intervals.

4. Frequency of testing will vary depending on a participant's progress, LSI-R score, and Partner requirements.
5. The scope of testing is sufficiently broad to detect the participant's primary drug of choice as well as other drugs of abuse, including alcohol.
6. Elements contributing to the reliability and validity of a testing process include, but are not limited to:
    a. Direct observation of sample collection;
    b. Verification temperature and measurement of creatinine levels in urine samples to determine the extent of water loading;
    c. Specific, detailed, written procedures regarding all aspects of sample collection, sample analysis, and result reporting;
    d. A documented chain of custody for each sample collected;
    e. Quality control and quality assurance procedures for ensuring the integrity of the process, and;
    f. Procedures for verifying accuracy when drug test results are contested.

A RSS program can provide alcohol or drug testing under the following conditions:

1. Train provider staff to administer alcohol and drug testing utilizing elements contributing to the reliability and validity of such testing.
2. Onsite alcohol and drug testing utilizing elements contributing to the reliability and validity of such testing.
3. All employees shall be instructed in the precautions to take when handling specimens and who has direct responsibility for supervising this activity.
4. Employees responsible for collection and testing shall be provided with protective apparel.
5. Provision shall be made for storage and disposal of samples and testing chemicals.
6. A department, service or staff member shall be assigned responsibility for developing these policies and procedures and for documenting their implementation.

Child Care Services

Child Care programs provide care and supervision to a client's child(ren) while the client is participating in clinical treatment and/or recovery support services. This includes care, control and supervision provided by an individual, other than a parent, during part of a twenty-four (24) hour day to a client's child(ren), less than 13 years of age, while the client is attending a treatment appointment or recovery support service.

1. Child care providers who provide services to children whose parents have left the premises must be licensed and meet the Idaho Administrative Procedures Act (IDAPA) Rules 16.06.02 *Rules Governing Standards for Child*

Care Licensing (Sect. 300). No child care license is required if parent remains on the premises.

2. Child Care programs will be expected to provide the following services and perform the following tasks:
   a. Provide services at a time and location that is suitable for the client to attend clinical treatment or recovery support services;
   b. Provide a setting that promotes and ensures the health, well-being and safety of the child(ren) in care.

Transportation Services

Transportation services are provided to clients who are engaged in treatment and/or recovery support services and who have no other means of obtaining transportation. Reimbursement is not available for transportation services to and from employment and to and from school.

Individual Transportation refers to any individual providing transportation who does not meet the definition of public or Agency Transportation and provides only transportation services to an eligible client. Adult and Adolescents must be transported separately with the exception with PWWC funded clients with the mom in the vehicle. **Note**: only Individual Transportation providers who are approved and have a Provider Agreement with the BPA Health can be reimbursed.

Public Transportation refers to any entity in the business of transportation that is organized to provide and actually provides transportation to the general public.

Clients not funded by Medicaid may utilize transportation services for any SUD funded treatment and RSS that are defined in IDAPA. SUD clients may also use authorized transportation to any services/appointments that are directly related to any goals documented on the client's Comprehensive Case Management or RSS Service Plans.

This may include but is not limited to:

1. Medical appointments
2. Dental services
3. Probation appointments
4. Employment assistance services
5. Idaho Division of Vocational Rehabilitation appointments/services
6. Client case staffing
7. Mental health services

Any transportation requests to recovery-oriented services not defined in IDAPA require documented confirmation of the appointment/service for which the client is receiving transportation services. Examples of documented confirmation could include a physician's note, appointment receipt, transport record, etc. Treatment providers and Case Managers should consider requirements regarding transportation services outlined in IDAPA and the transportation benefit limits when requesting client transportation.

Adolescent clients can not be transported in a vehicle with Adult clients.

Staffing (Planned Facilitation)

Staffing (planned facilitation) is to be used by professional staff for collaboration with external collateral sources and for completion and submission of IDOC monthly Status Report forms for clients with IDOC funding. Collaboration specifically addresses the client's treatment status or progress. Specific rules are as follows:

1. The clinical staffing with professionals outside of the clinician's agency may be billed when it is face-to-face interactions. The exception has been defined by IDOC (for clients with IDOC funding) to include the monthly Status Reports to the PO's.
2. Staffing internally to the agency on clients is expected, and is billable by the case manager, but not the clinician.
3. The case manager is encouraged to be the go between for the clinician and other outside agencies (e.g. POs, Medical Staff, vocational rehabilitation) and bill for the staffing with them. Case management staffing is much broader in scope than the clinicians. For any written reports other than the IDOC monthly Status Report, the client must be present while the report is authored to be reimbursement for time.
4. The recovery coach may staff the case internally, but not with other agencies.

8.3 General Billing

1. SUD funding in the BPA Health provider network uses the electronic health record, Web Infrastructure for Treatment Services (WITS)**.** All billing is done through WITS, as such, all SUD Providers are required to use WITS for billing purposes. BPA Health will manage billing appeals and use WITS to audit client files. WITS training is required for providers prior to being credentialed into the network. WITS Help Desk can be reached at (208) 332-7316.
2. BPA Health and the Provider shall cooperate and exchange information regarding alternative health coverage of Eligible Members and other information relative to coordination of benefits. *Reference section 6.1 of the Provider Agreement.*

3. Provider agrees to notify BPA Health of an Eligible Member's eligibility for other insurance. *Reference section 6.2 of the Provider Agreement.*
4. Provider agrees that all claims submitted to BPA Health shall be as a funding source of last resort. Provider agrees that they will exhaust all other possible funding sources available to the Member prior to submitting a claim to BPA Health for work under this contract. *Reference section 6.3 of the Provider Agreement.*

9. Independent Contractors

1. Provider shall perform assigned work as an independent contractor. Provider and BPA Health acknowledge that the Provider Agreement in no way limits Provider's rights or availability to other employment contemporaneously or following the performance of the Provider Agreement, and in no way limits BPA Health availability to contract with other providers. *Reference section 7.1 of the Provider Agreement.*
2. Provider and its respective employees and agents shall in no way be considered agents or representatives of BPA Health for any purpose, nor shall Provider or its agents and employees hold themselves out to be agents or representatives of BPA Health for any purpose. *Reference section 7.2 of the Provider Agreement.*

10. Safeguarding Protected Health Information (PHI)

1. Provider acknowledges that Provider is a "Covered Entity" as defined under HIPAA (45 C.F.R. § 160.102) and that as a Covered Entity, Provider is obligated, among other matters, to comply with the privacy and security provisions of HIPAA (45 C.F.R. § Part 164). *Reference section 8.1 of the Provider Agreement.*
2. In order to provide satisfactory assurance to BPA Health that it will appropriately safeguard all "Protected Health Information" (as defined under HIPAA (45 C.F.R. §160.103)), provided to or obtained by the Provider, and that it will comply with applicable law regarding Protected Health Information with respect to any task or activity that it performs on behalf of BPA Health, to the extent that BPA Health would be required to comply with such law, the Provider hereby agrees that the Provider will not use or further disclose the Protected Health Information other than as permitted or required under the Provider Agreement or as required by law. *Reference section 8.2 of the Provider Agreement.*
3. The permitted and required uses and disclosures of the Protected Health Information by the Provider are only those that are authorized by the Provider Agreement and are made to the Provider's employees, contractors, and agents, are directed to or required by BPA Health. The Provider will not use or

further disclose the Protected Health Information other than as described previously, except that the Provider may use the Protected Health Information for its own proper management and administration and to fulfill any present or future legal responsibilities of the Provider that are permissible under applicable state and federal privacy laws, and may disclose such information if the disclosure is required by law as provided for in 45 C.F.R. §164 *Reference section 8.3 of the Provider Agreement.*

4. The Provider's medical records pertinent to a Member shall be disclosed to BPA Health at its request in order that BPA Health can meet its obligations to perform quality assessment and utilization and peer-review. *Reference section 8.4 of the Provider Agreement.*
5. The Provider will use appropriate safeguards to prevent the use or disclosure of Protected Health Information other than as provided for in the Provider Agreement. *Reference section 8.5 of the Provider Agreement.*
6. The Provider will report to BPA Health any use or disclosure of the Protected Health Information not permitted by the Provider Agreement of which it becomes aware. *Reference section 8.6 of the Provider Agreement.*
7. The Provider will ensure that it will enter HIPAA compliant Business Associate Agreements with any subcontractors or agents to whom it provides Protected Health Information received from BPA Health and require such contractors or agents to agree to the same restrictions and conditions that apply to the Provider with respect to such information. Any such disclosures of Protected Health Information to subcontractors, agents, or other third parties shall be restricted to the minimum necessary to perform the function required. *Reference section 8.7 of the Provider Agreement.*
8. The Provider will give individual Members the right of access, amendment, and accounting, regarding their Protected Health Information in accordance with applicable law. *Reference section 8.8 of the Provider Agreement.*
9. The Provider will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from BPA Health available to BPA Health and the Secretary of the Federal Department of Health and Human Services for purposes of determining BPA Health's compliance with applicable law, subject to attorney-client and other applicable privileges. *Reference section 8.9 of the Provider Agreement.*
10. Provider agrees to comply with the HIPAA breach notification rules found at 45 C.F.R. § 164.400 *et seq.* Provider shall also notify BPA Health of any breach as defined in 45 C.F.R. § 164.402 and notify BPA Health of all actions taken by Provider to comply with 45 C.F.R. §164.402. *Reference section 8.10 of the Provider Agreement.*

11. Contract Terms

11.1 General Terms

1. The Provider Agreement shall be effective for an initial term of one (1) year from the effective date, and thereafter shall be automatically renewed for additional terms of one (1) year each, unless and until terminated in accordance with this article. *Reference section 9.1 of the Provider Agreement.*
2. Termination without Cause. The Provider Agreement may be terminated by either Party at any time without cause with at least ninety (90) days prior written notice to the other Party. *Reference section 9.2 of the Provider Agreement.*
3. Termination for Breach. The Provider Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this section will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. *Reference section 9.3 of the Provider Agreement.*
4. Immediate Termination or Suspension. Any of the following events shall result in the immediate termination or suspension of the Provider Agreement by Company, upon notice to Providers, at Company's discretion at any time:
   a. the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential;
   b. Provider's indictment, arrest or conviction of a felony or for any criminal charge related to or in any way impairing Provider's ability to treat Members;
   c. the loss or material limitation of Provider's insurance under Section 2.5 of the Provider Agreement;
   d. a determination by Company that Provider's continued participation in provider networks could result in harm to Members;
   e. the exclusion, debarment or suspension from participation in any governmental sponsored program, including, but not limited to, government programs, Medicare or the Medicaid program in any state;
   f. the listing of Provider in the HIPDB;
   g. change of control of Provider's practice to an entity not acceptable to Company;
   h. any false statement or material omission in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion;

i. the withdrawal, expiration or termination of the BPA Health contract with Idaho Department of Health and Welfare.

5. To protect the interests Members, Provider will give immediate notice to Company of any of the aforesaid events described in clauses (a) through (i), including notification of impending bankruptcy. The Company may, in its discretion, terminate the Provider agreement in writing when the Provider fails to comply with any applicable rule, term or provision of the Provider agreement, it deems appropriate. Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions under Idaho Code Sections 56-227, 56-227A, 56- 227B, and 56-209(h) and IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", as amended. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of the Provider agreement. Notice of these sections shall in no way imply that they represent an exclusive or exhaustive list of available action to deal with fraud and abuse. *Reference section 9.4 of the Provider Agreement.*
6. Rights and Obligations Upon Termination. Upon termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release the Provider or BPA Health of their obligations with respect to: (a) payments accrued to Provider prior to termination; (b) Provider's agreement not to seek compensation from Eligible Members for Covered Services prior to termination; and (c) completion of treatment of Eligible Members who are receiving care until continuation of the Eligible Members' care can be arranged by BPA Health as determined by the Medical Director or as required by applicable law or the Payer Contract. Services provided during continuation of care shall be reimbursed in accordance with the terms of the Provider Agreement. *Reference section 9.5 of the Provider Agreement.*
7. Notification of Provider Termination. Provider acknowledges the right of BPA Health to inform Eligible Members of Provider's termination. In the event the Provider Agreement is terminated, BPA Health may provide written notice within thirty (30) business days of receipt, or issuance of a notice of termination, to all Eligible Members who are seen on a regular basis by Provider, regardless of whether the termination was for cause or without cause. *Reference section 9.6 of the Provider Agreement.*
8. Survival of Obligations. Any obligations that cannot be fully performed prior to the termination of the Provider Agreement including, but not limited to, obligations in the following provisions set forth in this Section, shall survive the termination of the Provider Agreement; Section 10.3(Covered Person Hold Harmless); Section 2.2 (Records Retention/Inspection); Article VIII (Indemnification); Section 2.5(Insurance); Insurance); Article 12 (Dispute Resolution); Section 9.5(Rights and Obligations Upon Termination). *Reference section 9.7 of the Provider Agreement.*

11.2 Adverse Action

Providers who have received an adverse determination from the Credentialing Committee are afforded an opportunity to appeal the decision by way of an Appeals Committee. BPA Health will provide written notification within 10 business days when an adverse determination/action has been brought against a provider, the reasons for the action, and a summary of the appeal rights and process.

If the Credentialing Committee's recommendation is upheld by the Appeals Committee to suspend or terminate a provider due to clinical concerns, BPA Health will report the decision to the National Practitioner Data Bank, state licensing board(s), and any other agencies as required if applicable. This process applies to both physicians and non-physicians, and only pertains to provider decisions affecting patient care and quality (versus breach of contract).

If the Appeals Committee decision is to uphold the provider's contract termination, the decision is final and not subject to an appeal process with BPA Health.

12. Liability

1. BPA Health shall not be liable for any act, omission, default, negligence, misfeasance or nonfeasance of Provider, Provider's employees, or agents. *Reference section 10.1 of the Provider Agreement.*
2. Provider shall not be liable for any act, omission, default, negligence, misfeasance or nonfeasance of BPA Health, BPA Health's employees or agents. *Reference section 10.2 of the Provider Agreement.*
3. Each party shall indemnify and hold harmless the other party and its officers, employees and agents from and against all fines, claims, demands, suits, actions, or costs, including reasonable attorneys' fees, of any kind and nature, to the extent that they arise by reason of the indemnitor's acts or omissions. *Reference section 10.3 of the Provider Agreement.*

13. Selections

1. Provider acknowledges that BPA Health and Eligible Member have the option of selecting among providers, which have contracts with BPA Health. Provider therefore understands and agrees that no guarantees can be made that Provider will be selected for the provision of Covered Services for Eligible Members. BPA Health makes no representation of exclusivity to Provider. *Reference section 11.1 of the Provider Agreement.*

14. Disputes and Dispute Resolution Procedures

1. In the event that any appeal or grievance arises from the terms and conditions set forth in the Provider Agreement, both Provider and BPA Health agree to follow the Adverse Action Appeals procedure as outlined in section 4.2 in this Provider Manual. *Reference section 12.1 of the Provider Agreement.*
2. In the event any dispute arises from the terms and conditions set forth in the Provider Agreement between the parties, and is not resolved by the Adverse Action Appeals procedure, the parties agree to abide by the procedures, processes and remedies set forth in the Agreement applicable to the specific dispute or otherwise established by BPA Health for disputes of the type identified. Any and all dispute resolution procedures shall be conducted only between the parties and shall not include any Eligible Member unless such involvement of the Member is necessary to the resolution of the dispute, which determination shall be made in the sole discretion of BPA Health. If the dispute is not resolved by the parties within a reasonable time, the parties agree to binding arbitration in lieu of any legal remedy at law or in equity; provided, however, arbitration shall not be used to resolve disputes involving allegations of professional negligence of a party. *Reference section 12.2 of the Provider Agreement.*
3. The parties shall abide by the following procedures for the arbitration process;
    a. The party initiating the arbitration process shall send written notice to the other party setting forth the basis of the dispute and the party's desire to arbitrate. Arbitration shall be in accordance with the rules and procedures of the American Arbitration Association or another nationally recognized arbitration association acceptable to BPA Health.
    b. Arbitration shall be conducted in the location of BPA Health's main office and before a panel of three (3) arbitrators. Each party shall select one arbitrator and those two arbitrators shall select the third arbitrator.
    c. The arbitrators shall be bound by the terms and conditions set forth in the Agreement when such terms and conditions are set forth clearly and without ambiguity.
    d. The arbitrators may not award consequential, special, punitive or exemplary damages. The arbitrators may award costs, including reasonable attorney's fees, against a party. If the decision of the arbitrators does not include such award, the parties shall share equally the costs of the arbitration.

e. This provision does not limit the ability of either party to such temporary or preliminary injunctive relief against the other party in a court of competent jurisdiction.

f. The decision of the arbitrators shall be final in writing and shall be binding on the parties and enforceable under the laws of the state of Idaho.

(g)This provision shall survive the termination of the agreement.

Reference section 12.3 of the Provider Agreement.

15. General Provisions

1. Notices. Any notice required or permitted to be given in the Provider Agreement by either party to the other may be given by personal delivery in writing, or by registered or certified mail, postage prepaid, with return receipt requested. Notices delivered personally will be deemed communicated as of the time of actual receipt; mailed notices will be deemed communicated as of three days after mailing. *Reference section 13.1 of the Provider Agreement.*
2. Severability. If any provision of the Provider Agreement, or the application of any provision to any party or any circumstances, shall be determined to be invalid, illegal or unenforceable in any respect in any instance, then such determination shall not affect the validity, legality, and enforceability of such provision in any other instance, or the validity, legality, or enforceability of any other provision of the Agreement. *Reference section 13.2 of the Provider Agreement.*
3. Governing Law. The Provider Agreement shall be governed by and construed in accordance with the laws of the State of Idaho. *Reference section 13.3 of the Provider Agreement.*
4. Assignment. The Provider Agreement may not be assigned by either party without the express written consent of the other. *Reference section 13.4 of the Provider Agreement.*
5. Enforceability. The failure of either party to enforce or insist upon compliance with any provisions of the Provider Agreement in any instance shall not be construed as or constitute a waiver of that party's right to enforce or insist upon compliance with such provision, rule, or regulation, either currently or in the future. *Reference section 13.5 of the Provider Agreement.*
6. Entire Agreement. The Provider Agreement (including any attached exhibits and schedules) contains all of the covenants and agreements between the parties with respect to the rendering of Covered Services, and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. *Reference section 13.6 of the Provider Agreement.*

7. Confidentiality of Terms and Conditions. The terms of the Provider Agreement and any attachments, schedules or exhibits are confidential and shall not be disclosed except as expressly provided in the Provider Agreement, or as required by law. *Reference section 13.7 of the Provider Agreement.*

16. Funding Source and Partner Specific Information

The BPA Health website Resource Page includes documents specific to different funding sources and Partners. You can find documents about:

- IDOC Funding
- IDJC Funding
- ISC/Drug Court Funding
- PWWC Specialty Network
- IROC Network
- Enhanced Safe & Sober Housing

These documents offer important information and detailed guidelines. We regularly add new information and resources to the website and encourage Agencies to check back from time to time. If you can't find the information that you're looking for, please contact us!