Amendment Number 24 (25)
Prepaid Health Plan Services
#30-190029-DHB – PHP Name

THIS Amendment to the Prepaid Health Plan Services Contract #30-190029-DHB – PHP Name (Contract) awarded February 4, 2019, and subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and PHP Name (Contractor), each, a Party and collectively, the Parties.

Background:
The purpose of this Amendment is to make clarifications, technical corrections and updates related to the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

I. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
II. Section V. Scope of Services;
III. Section VI. Contract Performance; and
IV. Section VII. Attachments.

The Parties agree as follows:

I. Modifications to Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections

Specific subsections are modified as stated herein.

a. *Section III. A. Definitions* is revised to add the following newly defined term:

182. Health care Clearinghouse: Has the same meaning as Health care Clearinghouse as defined in 45 C.F.R. § 160.103**.**

183. High-Cost Drugs: Specific to the Department's Tribal Payment Policy, High-Cost Drugs are considered to be covered outpatient drugs with a total calculated allowable amount greater than one thousand dollars ($1,000) consistent with Page 1a.2, Section 12 of Attachment 4.19-B of the Medicaid State Plan.

b. *Section III. C. Contract Term, 1.* is revised and restated in its entirety as follows:

1. The Contract Term is February 4, 2019 through December 1, 2027, and shall include an implementation period and Contract Years 1 through 7 as follows:

Third Revised and Restated Section III. C. Table 1: Contract Term	
Contract Period	**Effective Dates**
Implementation Period	February 4, 2019 through June 30, 2021
Contract Year 1	July 1, 2021 through June 30, 2022
Contract Year 2	July 1, 2022 through June 30, 2023
Contract Year 3	July 1, 2023 through June 30, 2024
Contract Year 4	July 1, 2024 through June 30, 2025
Contract Year 5	July 1, 2025 through June 30, 2026
Contract Year 6	July 1, 2026 through June 30, 2027
Contract Year 7	July 1, 2027 through December 1, 2027

c. ***Section III. D. Terms and Conditions, 28. MEDIA CONTACT APPROVAL AND DISCLOSURE*** **is revised and restated in its entirety as follows:**

28. MEDIA CONTACT APPROVAL AND DISCLOSURE

a. Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. In the event the Contractor is contacted by the media for information related to the terms of this Contract or a recipient of services under the Contractor shall make immediate contact with the Department when the contact occurs. Contractor must submit any information related to such media release or public disclosure to the Department for review and approval at least seven (7) business days in advance of intended disclosure. The Department may, at its sole discretion, object to its publication or require changes to the information intended for public release. The requirements of this Section shall not apply to any information the Contractor is required by law to disclose.

b. Media Interviews: Contractor shall not agree to participate in a media request for an interview related to the terms of this Contract prior to obtaining prior approval from the Department, which approval shall not be unreasonably withheld. Upon receipt of a request for an interview, Contractor shall provide the information outlined in the Media Interview Request Instructions for Health Plans to the Department for review.

d. ***Section III. D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT:, e. Enhanced Case Management Pilots to Address Unmet Health-Related Needs Payments, also known as the Healthy Opportunities Pilot Payments, ii. Capped Allocation, c), i.*** **is revised and restated in its entirety as follows:**

i. Before adjusting Contractor's capped allocation, the Department will inform Contractor within thirty (30) Calendar Days that it is at risk of an adjustment and allow Contractor to submit a report explaining its anticipated spending through the remainder of the Pilot Service Delivery Period for the Department's consideration. The Contractor shall submit this report within ten (10) Calendar Days of being informed by the Department that it is at risk of an adjustment.

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

a. ***Section V. A. Administration and Management, 1. Program Administration, h. Compliance with Department Policies, i., s)*** **is revised and restated in its entirety as follows:**

s) North Carolina Medicaid Withhold Program Guidance as identified in *Section VI.C. Withholds;*

b. ***Section V. A. Administration and Management, 5. Implementation, f., ii.*** **is revised and restated in its entirety as follows:**

ii. End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting. The Department, if deemed necessary for the project execution, shall develop and provide an End-to-End test plan aligned with specific requirements for the program that includes all systems that are part of End-to-End testing. At a minimum, the End-to-End testing Plan shall include:

a) High level description of the End-to-End testing scope;

b) High level overall End-to-End testing duration;
c) Applications or systems that are part of the End-to-End testing; and
d) Integrations that are part of the End-to-End testing.

c. ***Section V. B. Members, 1. Eligibility for Medicaid Managed Care, d. Medicaid Managed Care eligibility:, iii., h)*** **is revised and restated in its entirety as follows:**

h) Beneficiaries who are inmates of prisons, as provided in NCGS § 108D-40(a)(9);

d. ***Section V. B. Members, 1. Eligibility for Medicaid Managed Care, d. Medicaid Managed Care eligibility:, iii., j)-k)*** **is revised and restated in its entirety as follows:**

j) Beneficiaries being served through Community Alternative Program for disabled Adults (CAP/DA) (includes beneficiaries receiving services under CAP/Choice);

k) Beneficiaries with services provided through the Program of All Inclusive Care for the Elderly (PACE)[3]; and

e. ***Section V. B. Member, 1. Eligibility for Medicaid Managed Care, d. Medicaid Managed Care eligibility:, iii.*** **is revised and restated in its entirety to add the following:**

l) Beneficiaries who are residing in carceral settings other than prisons and whose Medicaid eligibility has been suspended, as provided in NCGS § 108D-40(a)(9a).

f. ***Section V. B. Members, 3. Member Engagement, h. Written and Oral Member Materials, ii., d), 1. is*** **revised and restated in its entirety as follows:**

1. Taglines are required on materials that are critical for potential members and members to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d). For all materials requiring a tagline, the PHP shall use the Department-developed Auxiliary Aids and Interpreter Services Taglines Template.

g. ***Section V. B. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vi. Internal Plan Appeals, h) Request for Plan Appeals*** **is revised and restated in its entirety to make a technical correction to subsection numbering as follows:**

h) Request for Plan Appeals
1. The PHP shall allow Members, or an authorized representative, sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination to file a request, orally or in writing, for an appeal with the PHP. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).
2. Reserved.
3. The PHP shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing, receipt of each standard appeal request, whether received orally or in writing, within five (5) calendar days of receipt of the request. 42 C.F.R. § 438.406(b)(1).

[3] The Department includes beneficiaries with services provided through the PACE program as a population excluded from managed care pursuant to Section 4.(4)d. of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, which excludes all PACE program services from Medicaid Managed Care

4. Standard resolution of appeals
    i. The PHP shall provide written notice of resolution of the appeal to the Member and/or authorized representative as expeditiously as the Member's health condition requires and within thirty (30) calendar days of receipt of a standard appeal request. 42 C.F.R. § 438.408(b)(2).
    ii. The PHP shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing appeal request form consistent with. 42 C.F.R. § 438.408(e).
5. Extension of standard resolution of appeal
    i. The PHP may extend the timeframes for standard resolution of an appeal request by up to fourteen (14) calendar days if
        a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. § 438.408(b)(1).
            i. If the timeframe is extended other than at the Member's request, the PHP shall do the following:
                a. Make reasonable efforts to give the Member oral notice of the delay;
                b. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
                c. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(ii).
    ii. The PHP shall use a Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution. The Notice shall include:
        a) The timeframe for extension;
        b) The reason for extension;
        c) A statement on the Member's right to file a grievance if he or she disagrees with the extension; and
        d) A statement regarding the availability of assistance with the appeals process and the ability to call the PHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).
    iii. The PHP shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language. The PHP shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Member may obtain the Utilization Management clinical review or decision-making criteria. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2).

h. *Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered services:, xiii.-xiii.* is revised and restated in its entirety to make a technical correction to subsection numbering as follows:

xiii. IMD-SUD Services
1. Under North Carolina's 1115 waiver authority, the PHP shall provide coverage for Substance Use Disorder services for Members aged twenty-one (21) to sixty-four (64) in an Institute for Mental disease (IMD), as well as any other State Plan services for which they may be eligible during their stay in the IMD.

2. The PHP shall provide the Department with a report every other week on members utilizing IMD-SUD services as defined in *Section VII.J. Reporting Requirements*. The report shall be submitted to the Department every other Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

xiv. For beneficiaries newly enrolled in the PHP with no immediately prior period of Medicaid managed care enrollment or fee-for-services enrollment with inpatient coverage, the PHP shall be responsible for any diagnosis-related group based inpatient facility claims if the beneficiary's first day of PHP enrollment is during the hospital stay.

i. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, d. Medical Necessity*** **is revised to add the following:**

x. Consistent with guidance from the American Academy of Pediatrics, the PHP should apply the following professional standards in conducting an EPSDT medical necessity review:
   a) Traditional evidence grading (patient-centered or scientific evidence for children) with a hierarchy or algorithm of standards applied;
   b) Professional standards of care for children; or
   c) Consensus expert pediatric opinion.

j. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, xiii., f)*** **is revised to add the following:**

7. Certain Local Health Department services: The PHP shall not require Members to obtain a referral or prior authorization for Sexually Transmitted Infection and/or Tuberculosis services rendered at a Local Health Department.

k. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, g. In Lieu of Services, i.*** **is revised and restated in its entirety as follows*:***

i. The PHP may use In Lieu of Services (ILOS), services or settings that are not covered under the North Carolina Medicaid State Plan, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)(2)i-~~iv~~.

l. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, g. In Lieu of Services, ii.*** **is revised and restated as follows with no revisions to subsections a)-d):**

ii. The PHP shall submit the Department's standardized Service Request Form, prior to implementation to the Department for approval on an annual cadence.

m. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing, v. Exceptions for cost sharing:, e)*** **is revised and restated in its entirety as follows:**

e) The PHP shall not impose cost-sharing on antiretroviral medications used to treat HIV for the purpose of reducing viral load, opioid antagonist medications used to treat an opioid overdose, medications used to treat Opioid Use Disorder, and nicotine replacement therapy used to treat nicotine addiction and aid in smoking cessation.

n. ***Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, d. Utilization management, ii.*** **is revised and restated in its entirety as follows:**

ii. For pharmacy services, the PHP shall follow the existing Medicaid Fee-for-Service clinical coverage policies, prior authorization (PA) criteria, and clinical criteria, and Preferred Drug List as described below in the UM

Program. The PHP shall align any of its clinical and prior authorization criteria with all of the requirements in the documents listed below:

a) Clinical Coverage Policies: *Section V.C. Table 6: Required Pharmacy Clinical Coverage Policies* below.
b) Prior Authorization Drugs and Clinical Criteria: Forms for Drugs and/or drug classes requiring prior approval are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html. Policies and clinical criteria for Drugs and/or drug classes subject to clinical criteria are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html.
c) Reserved.
d) Preferred Drug List: https://medicaid.ncdhhs.gov/preferred-drug-list.

o. *Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, d. Utilization management, iv.* is revised to add the following:

k) Prior authorization policies and pharmacy point of service edits implemented by the PHP shall be consistent with the FDA label or medically accepted uses, as defined in Section 1927(k)(6) of the Social Security Act, as part of its UM program to ensure Member safety, to prevent overprescribing and inappropriate prescribing of drugs.

p. *Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, d. Utilization management, vi.* is revised and restated in its entirety as follows:

vi. The PHP may require utilization edits or PA for drugs based on the drug's FDA approved indication(s) and use(s) or medically acceptable uses, as defined in Section 1927(k)(6) of the Social Security Act, until the Department determines the need for and establishes clinical coverage and PA criteria or determines that clinical coverage criteria or prior authorization is not to be applied to a drug or drug class.

q. *Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, iii.-vi.* is revised and restated in its entirety as follows:

iii. Reserved.
iv. Reserved.
v. Reserved.
vi. Reserved.

r. *Section V. C. Benefits and Care Management, 4. Transition of Care, e. Transition of Care for Members enrolled in the Healthy Opportunities Pilot, ii., h), 2.* is revised and restated in its entirety as follows:

2. Within ten (10) Calendar Days of notification via the Department's standard eligibility file that a Pilot enrollee is transitioning to Medicaid Direct, the Tribal Option, in advance of the launch of Healthy Opportunities Pilot for Tribal Option Members, or to a county not covered by the Healthy Opportunities Pilots, the PHP shall inform the HSO(s) outside of NCCARE360 (e.g., by phone or through the HSO's Network Lead) of the date of disenrollment. The PHP shall bear the financial responsibility of authorized Pilot services that have been delivered to the Pilot enrollee through the date of disenrollment. The PHP will not be required to return pilot funding to the Department for authorized Pilot services delivered prior to the date of disenrollment.

s. *Section V. C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, a) General Requirements* is revised to add the following:

8. The PHP shall submit the Clinically Integrated Networks (CIN) Contracting Report to the Department as described in *Attachment J: Ninth Revised and Restated Reporting Requirements*.

t. ***Section V. C. Benefits and Care Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, v. Pilot Periods, b)*** **is revised to add the following**:

6. Pilot Service Delivery Period V: November 1, 2024 – June 30, 2025.
7. Pilot Service Delivery Period VI: July 1, 2025 – June 30, 2026.

u. ***Section V. D. Providers, 2. Provider Network Management, c. Provider Contracting, xxiv. Tobacco-free Policy*** **is revised and restated in its entirety as follows:**

xxiv. Tobacco-free Policy

a. Starting January 1, 2027, the PHP shall require contracted Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to individuals they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

b. Starting January 1, 2027, the following partial tobacco-free policy shall be required in Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities:
    1. Use of tobacco products is prohibited indoors when the building or home in which the provider operates is under the provider's control as owner or lessee.
    2. Outdoor areas of the property under the provider's control as owner or lessee must:
        a) Ensure access to common outdoor space(s) free from exposure to tobacco use; and
        b) Prohibit staff/employees from using tobacco products anywhere on the property.
        c) Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

c. Provider Monitoring
    1. Starting January 1, 2027, the PHP shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The PHP shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The PHP shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

v. ***Section V. D. Providers, 2. Provider Network Management, l. Provider Directory, vi.*** **is revised and restated in its entirety as follows:**

vi. The consumer-facing provider directory must comply with 42 C.F.R. § 438.10(h)(1) and shall include the following information, at a minimum:
    a. Provider name;

b. Provider demographics (first, middle, and last name, gender);
c. Reserved;
d. Provider DBA Name;
e. Reserved;
f. Reserved;
g. Provider type (PCP, etc.);
h. Reserved;
i. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
j. Street address(as) of service location(s);
k. County(ies) of service location(s);
l. Telephone number(s) at each location;
m. After hours telephone number(s) at each location;
n. Website URL(s), as applicable;
o. Provider specialty by location;
p. Whether provider is accepting new beneficiaries;
q. Provider's cultural and linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
r. Whether provider has completed cultural competency training, including description of training;
s. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
t. A telephone number a Member can call to confirm the information in the directory;
u. Reserved;
v. Essential provider indicator;
w. IHCP indicator;
x. Reserved~~.~~; and
y. Whether the provider offers telehealth services.

w. *Section V. G. Program Operations, 1. Service Lines, t. Behavioral Health Crisis Line, iii.* is revised and restated in its entirety as follows:

iii. The PHP Behavioral Health Crisis Line must have warm transfer capabilities to crisis emergency service lines, including (but not necessarily limited to) 911, 988, and mobile crisis teams. In instances where there is immediate danger to self or others, the PHP shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
   a) The PHP Behavioral Health Crisis Line must have warm transfer capabilities to the NC peer warm line (1- 855-PEERS NC).

x. *Section V. G. Program Operations, 1. Service Lines, t. Behavioral Health Crisis Line* is revised to add the following:

vii. The PHP Behavioral Health Crisis Line shall have the capability to refer Members to providers for the appropriate level of behavioral health services within the timeframes set forth in *Section VII. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards*.

y. *Section V. H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, i.* is revised and restated in its entirety as follows:

i. The PHP shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when Department decisions warrant reprocessing (i.e. Member retrospective eligibility determinations or plan enrollment

changes). The PHP, and any Subcontractors who process claims on behalf of the PHP, shall have the capability to accept and process claims through an industry-standard Health Care Clearinghouse in standard HIPAA transaction formats (ASC X12, NCPDP, 837P and 837I).

z. ***Section V. H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iv. b)*** **is revised and restated in its entirety as follows:**

b) The PHP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes. The PHP, and any Subcontractors who process claims on behalf of the PHP, shall implement Health Care Clearinghouse integration.

aa. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, i., a) 2.-3.*** **is revised and restated in its entirety as follows:**

2. The PHP shall pay or deny a Clean Medical Claim within thirty (30) Calendar Days of receipt of the Clean Claim.
3. A Medical Pended Claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

bb. ***Section V. H. Claims and Encounter Management, 1. Claims, g. System Standards*** **is revised to add the following:**

iv. The solution for electronic claim submission shall, at a minimum, allow providers to submit claim transactions electronically through an industry standard Health Care Clearinghouse, in standard HIPAA transaction formats (ASC X12, NCPDP, 837P and 837I). The PHP, and any Subcontractor(s) that process claims on behalf of the PHP, shall implement, if not already implemented, the capability to accept and process claims through an industry-standard Health Care Clearinghouse in standard HIPAA transaction formats (ASC X12, NCPDP, 837P and 837I) by no later than July 1, 2025.

cc. ***Section V. H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix., a) Timeliness, 3., i.*** **is revised and restated in its entirety as follows:**

i. Medical: for purposes of determining if the PHP has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, and value-based payments to providers. A complete list of value-based payment types can be referenced in the Encounter Data Submission Guide.

dd. ***Section V. H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix., c) Accuracy, 1., i.*** **is revised and restated in its entirety as follows:**

i. Medical: for purposes of determining if the PHP has met the accuracy encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, and value-based payments to providers. A complete list of value-based payment types can be referenced in the Encounter Data Submission Guide.

ee. ***Section V. H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix.*** **is revised to add the following:**

f) Historical Value-based Payment Encounters

1. The PHP shall submit no later than one hundred eighty (180) Calendar Days from the availability of additional value-based payment (VBP) encounter types within the EPS, all encounters for those VBP payment types made prior to the implementation of the new VBP encounter type. A complete list of value-based payment types can be referenced in the Encounter Data Submission Guide.

III. <u>Modifications to Section VI. Contract Performance</u>

Specific subsections are modified as stated herein.

a. ***Section VI. Contract Performance, B. Service Level Agreements, Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024),*** **is revised and restated in its entirety as follows:**

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Member Enrollment Processing	The PHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PHP to its system to trigger enrollment and disenrollment processes.	Monthly	$1,000 per eligibility file that does not meet the submission guidelines of the eligibility file.
2.	Member Appeals Resolution - Standard	The PHP shall resolve at least ninety-eight percent (98%) of PHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
3.	Member Appeals Resolution - Expedited	The PHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the	Monthly	$5,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			grievance divided by the total number of grievances filed during the measurement period.		
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	$100,000 per quarter
6.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls	Monthly	$5,000 per service line per month
7.	Call Response Time/Call Answer Timeliness - Member Services line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
8.	Call Wait/Hold Times - Member Services line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
9.	Call Abandonment Rate – Member Services line	The abandonment call rate shall not exceed five percent (5%)	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during	Monthly	$10,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			open hours of operation.		
10.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$15,000 per month
11.	Call Wait Time/Hold Times - Behavioral Health Crisis Line	The PHP shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$15,000 per month
12.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
13.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$10,000 per month
14.	Call Wait/Hold Times - Nurse Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of	Monthly	$10,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			calls received by the service line during the measurement period.		
15.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
16.	Call Response Time/Call Answer Timeliness - Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
17.	Call Wait/Hold Times - Provider Support Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
18.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month
19.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total	Monthly	$10,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			number of calls received by the service line during the measurement period.		
20.	Call Wait/Hold Times - Pharmacy Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
21.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
22.	Encounter Data Timeliness – Medical	The PHP shall submit ninety-eight percent (98%) of medical encounters within thirty (30) Calendar Days after payment whether paid or denied. *For purposes of this standard, medical encounters include 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x; and monthly medical home and care management fees and value-based payments as specified in the Encounters Submission Guide.*	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per encounter per Calendar Day
23.	Encounter Data Timeliness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy encounters within	The number of unique transactions submitted divided by the number of	Weekly	$100 per encounter per Calendar Day

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		seven (7) Calendar Days after payment whether paid or denied. *For purposes of this standard, pharmacy encounters only include 837- P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters.*	unique transactions which should have been submitted to the Department as an encounter.		
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims. *For purposes of this standard, medical encounters include 837-P encounters and 837-I encounters; and monthly medical home and care management fees and value-based payments as specified in the Encounters Submission Guide.*	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$25,000 per month
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. *For purposes of this standard, pharmacy encounters only include NCPDP encounters.*	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$50,000 per week
26.	Encounter Data Reconciliation - Pharmacy	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$100,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
27.	Website User Accessibility	The PHP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.		Daily	$2,500 per occurrence
28.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month
29.	Timely response to electronic inquiries	The PHP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) business days of receipt.	Electronic inquires includes communications received via email, fax, web or other communications received electronically by the PHP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence (each communication outside of the standard for the month)
30.	Encounter Data Reconciliation - Medical	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days. *For purposes of this standard, medical encounters only include 837- P encounters and 837-I encounters.*	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$10,000 per month
31.	Call Response Time/Call Answer Timeliness – NEMT Member Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned within	Monthly	$10,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.		
32.	Call Wait/Hold Times – NEMT Member Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
33.	Call Abandonment Rate – NEMT Member Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
34.	Call Response Time/Call Answer Timeliness – NEMT Provider Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
35.	Call Wait/Hold Times – NEMT Provider Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
36.	Call Abandonment Rate – NEMT Provider Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
37.	Non-Emergency Transportation – Hospital Discharge	The PHP shall ensure that at least ninety-eight percent (98%) of Medicaid Members discharged from hospitals or emergency departments are picked up within three (3) hours of receipt of the request from the Member, the Member's authorized representative, or hospital staff, or within (3) hours of the Member's scheduled discharge, whichever is later, as specified in the *NC Non-Emergency Medical Transportation Managed Care Policy*.	The number of trips per month that Contractor fails to pick up at least ninety-eight percent (98%) of Medicaid Members being discharged from a hospital or emergency department within the established timeframes after receipt of a request from the Member, the Member's authorized representative, or hospital staff for NEMT.	Monthly	$3,000 per trip for any delay beyond the three (3) hour pick-up requirement for any trip above the 2% threshold
38.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the PHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	The PHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the PHP within the required timeframe divided by the total number of new Members enrolled in the PHP during the measurement period.	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
39.	Member Welcome Packet Timeliness – Separate Mailing for	The PHP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member	The number of welcome letters and Member handbooks (mailed	Monthly	98.99% - 95%: $5,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	Welcome Letter and Member Handbook *Applies if the PHP utilizes separate mailings to send components of the Welcome Packet*	handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	separately from identification cards) mailed by the PHP within the required timeframe divided by the total number of new Members enrolled in the PHP during the measurement period.		94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
40.	Member Welcome Packet Timeliness – Separate Mailing for Identification Card *Applies if the PHP utilizes separate mailings to send components of the Welcome Packet*	The PHP shall meet or exceed ninety-nine percent (99%) of identification cards (mailed separately from welcome letters and Member handbooks) mailed within the timeframes specified in *Section V.B.3.Member Engagement.*	The number of identification cards (mailed separately from welcome letters and Member handbooks) mailed by the PHP within the required timeframe divided by total number of new Members enrolled in the PHP during the measurement period.	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
41.	Provider Welcome Packet Timeliness	The PHP shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in *Section V.D.3. Provider Relations and Engagement.*	The number of Provider Welcome Packet sent by the PHP within the required timeframe divided by the total number of new providers who have executed a contract with the PHP during the measurement period.	Quarterly	97.99% - 95%: $5,000 per quarter 94.99% - 80%: $7,500 per quarter 79.99% or less: $10,000 per quarter
42.	Non-Emergency Medical Transportation – Approved Trips	The PHP shall complete ninety-nine and one-half percent (99.5%) of all approved NEMT trips.	The number of NEMT trips approved by the PHP minus the number of NEMT trips missed due to Provider No-Show or No Provider Vehicle Available (NPVA), as those terms are defined in the BCM011-J-SP operational report, divided by the total number of NEMT trips approved by the PHP.	Monthly	99.25%-99.49% = $15,000 per month 99.01%-99.24% = $20,000 per month

Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			NEMT trips for hospital discharges will not be included in determining compliance with this SLA.		99% or less = $25,000 per month

b. ***Section VI. Contract Performance, C. Withholds, 1.,*** **is revised and restated in its entirety as follows:**

1. To encourage performance improvement on priority areas established by the Department and in accordance with the Department's Quality Strategy, the PHP shall participate in the Department's withhold program, as described in this Section and detailed in the applicable North Carolina Medicaid Withhold Program Guidance. Nothing in this Section applies to HOP Withholds. HOP Withholds are governed by *Section V.D.4.aa. Healthy Opportunities Pilot Payments* and *Section V.I.6. Healthy Opportunities Pilot Payments*.
    i. Pursuant to *Section III.D.32. PAYMENT AND REIMBURSEMENT,* the Department shall withhold a set percentage of the PHP's total capitation payments for each performance period subject to a Withhold Arrangement. In accordance with N.C. Gen. Stat. § 108D-65(5)a., the total amount withheld by the Department for a defined performance period shall not exceed three and one-half percent (3.5%) of the PHP's total capitation payments for the Rating Period during which the Department withholds funds for the performance period identified in the North Carolina Medicaid Withhold Program Guidance.
    ii. At a minimum, for any Withhold Arrangement implemented by the Department, the applicable North Carolina Medicaid Withhold Program Guidance shall define the following:
        a) The performance measure(s) and the applicable performance targets for each identified measure;
        b) The performance period;
        c) The percentage of the PHP's total capitation payment subject to the withhold;
        d) The manner and timeframes for the withholding of funds by the Department for the applicable performance period; and
        e) The Department's scoring methodology for determining performance against full or partial repayment of withheld funds.
    iii. North Carolina Medicaid Withhold Program Guidance
        a) For each withhold performance period(s) implemented by the Department, the applicable program guidance is as follows:
            1) January 1, 2024 to December 31, 2024 - North Carolina Medicaid Standard Plan Withhold Program Guidance: 2024.
            2) January 1, 2025 to December 31, 2025 - North Carolina Medicaid Standard Plan Withhold Program Guidance: 2025.
        b) Any North Carolina Medicaid Withhold Program Guidance that is developed by the Department in accordance with this Section will be located here: https://medicaid.ncdhhs.gov/reports/quality-management-and-improvement.

c. ***Section VI. Contract Performance, C. Withholds, 8. Bonus Pools for the Withhold Program,*** **is revised and restated in its entirety as follows:**

8. Bonus Pools for the Withhold Program
   i. In its sole discretion and based on the availability of funds, the Department may implement a Bonus Pool for specific performance measures as an incentive for the PHP to further improve its performance on the identified measure(s) during the applicable performance period.
   ii. Any established Bonus Pool(s) shall include a Loss Limit that is set by the Department and defined in the applicable North Carolina Medicaid Withhold Program Guidance.
   iii. The applicable North Carolina Medicaid Withhold Program Guidance shall define the criteria for participation in a Bonus Pool and how any PHP eligible to participate may be awarded Bonus Pool funds.
   iv. If no PHP is eligible to participate in an established Bonus Pool, the funds will be retained by the Department.
   v. Following the issuance of the Notice of Withhold Determination and the resolution of any disputes that may arise under *Section VI.A.e.vii. Dispute Resolution* regarding the withhold determination, the Department shall provide written notice to the PHP detailing the establishment of any Bonus Pool(s) based on the availability of funds, whether the PHP was eligible to participate in any established Bonus Pool(s), and whether the PHP was awarded funds from any of the Bonus Pool(s). As applicable, payment of any Bonus Pool funds owed to the PHP shall be made by the Department to the PHP by no later than sixty (60) Calendar Days of the date on the written notice.
   vi. The Department's determination to award funds to a PHP that the Department deems eligible to participate in a Bonus Pool shall be made in the Department's sole discretion based on the criteria specified in the applicable North Carolina Medicaid Withhold Program Guidance and is not subject to dispute by the PHP.

IV. Modifications to Section VII. Attachments

Specific Attachments are modified or added as stated herein.

a. ***Attachment G. Ninth Revised and restated Required Standard Provisions for PHP and Provider Contracts*** **is revised and restated in its entirety as** ***Attachment G. Tenth Revised and Restated Required Standard Provisions for PHP and Provider Contracts*** **and attached to this Amendment.**

b. ***Attachment J. Eight Revised and Restated Reporting Requirements*** **is revised and restated in its entirety as** ***Attachment J. Ninth Revised and Restated Reporting Requirements*** **and attached to this Amendment.**

c. ***Attachment M.10. Second Revised and Restated Approved <PHP Name> In Lieu of Services*** **is revised and restated in its entirety as** ***Attachment M.10. Third Revised and Restated Approved <PHP Name> In Lieu of Services*** **and attached to this Amendment.**

d. ***Attachment M.16. Tribal Payment Policy*** **is incorporated into the Contract and attached to this Amendment.**

e. ***Attachment N. Business Continuity Management Plan*** **is revised and restated in entirety as** ***Attachment N. Reserved*** **and attached to this Amendment.**

V. Effective Date

This Amendment is effective July 1, 2025, unless otherwise explicitly stated herein, subject to approval by CMS.

VI. Other Requirements

Unless expressly amended herein, all other terms and conditions of the Contract, as previously amended, shall remain in full force and effect.

Execution:

By signing below, the Parties execute this Amendment in their official capacities and agree to the amended terms and conditions outlined herein as of the Effective Date.

Department of Health and Human Services

_____ Date: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

Plan Name

_____ Date: _____

Plan Signature Authority

Attachment G. Tenth Revised and Restated Required Standard Provisions for PHP and Provider Contracts

The PHP shall develop and implement contracts with providers to meet the requirements of the Contract. The PHP's provider contracts shall at a minimum comply with the terms of the Contract, state and federal law, and include required applicable standard contracts clauses.

1. **Contracts between the PHP and Providers, must, at a minimum, include provisions addressing the following:**
    a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PHP utilizes the definition as found in Section III.A. of the PHP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
    e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the PHP's insolvency the contract must address:
            1. Transition of administrative duties and records; and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's Network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and to notify the Department of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
        ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
            1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
            2. During Provider Credentialing under Full Implementation, no less

frequently than every three (3) years, except as otherwise permitted by the Department.

g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PHP and to notify the PHP of subsequent changes in status of professional liability insurance on a timely basis.
h. Member Billing: The contract must address the following:
    i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance that the PHP may not cover or continue to cover specific services and the Member to receive the service; and
    ii. Any provider's responsibility to collect applicable Member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
i. Provider Accessibility. The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PHP's standards for provider accessibility.
j. Eligibility *Verification. The contract must address the PHP's obligation to provide a mechanism that allows providers to verify Member eligibility, based on current information held by the PHP, before rendering health care services.*
k. Medical Records. The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
    i. Maintain confidentiality of Member medical records and personal information and other health records as required by law;
    ii. Maintain adequate medical and other health records according to industry and PHP standards; and
    iii. Make copies of such records available to the PHP and the Department in conjunction with its regulation of the PHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
l. Member Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the Member in regard to Member appeals and grievance procedures.
m. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3- 227(a)(5).
n. Data to the Provider: The contract must address the PHP’s obligations to provide data and information to the provider, such as:
    i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
    ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.

iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.

o. Utilization Management: The contract must address the provider's obligations to comply with the PHP's utilization management programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

p. Provider Directory: The provider's authorization and the PHP's obligation to include the name of the provider or the provider group in the provider directory distributed to Members.

q. Dispute Resolution: Any process to be followed to resolve contractual differences between the PHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in Section V.D.5. Provider Grievances and Appeals.

r. Assignment: Provisions on assignment of the contract must include that:
   i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PHP.
   ii. The PHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

s. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.

t. Interpreting and Translation Services: The contract must have provisions that indicate:
   i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
   ii. The provider must ensure the provider's staff are trained to appropriately communicate with patients with various types of hearing loss.
   iii. The provider shall report to the PHP, in a format and frequency to be determined by the PHP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

u. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.

v. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH care management model and requirements consistent with the Department's Advanced Medical Home Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's Advanced Medical Home Program.

w. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with a LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

x. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
    i. G.S. 58-3-200(c).
    ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
    iii. G.S. 58-50-270 (1), (2), and (3a).
    iv. G.S. 58-50-275 (a) and (b).
    v. G.S. 58-50-280 (a) through (d).
    vi. G.S. 58-50-285 (a) and (b).
    vii. G.S. 58-51-37 (d) and (e).

y. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in Section V.D.4. of the PHP Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the PHP shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in Attachment H. Third Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers includes the information required by this provision or to contracts when the PHP and provider have mutually agreed to an alternative reimbursement arrangement. When a PHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

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

aa. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the PHP shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

bb. Physician Advisor Use in Claims Dispute: The contract must indicate that the PHP shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative

for a claim or prior authorization in review or dispute.

cc. Designated Pilot Care Management Entities: For all contracts with Designated Pilot Care Management Entities, provisions that indicate:
    i. The Designated Pilot Care Management Entity shall:
        a) Utilize NCCARE360 for functions outlined in *PHP Contract Sections V.C.8.e.ii.a. and V.C.8.g.xiv.*
        b) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, v.b.*
        c) Manage transitions of care for Pilot-enrolled Members as outlined in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, a.v.c. Transitional Care Management* for Members that change health plans.
        d) Perform Pilot-related care management responsibilities as outlined in *PHP Contract Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot*.
        e) Abide by the Pilot provider complaint process described in *PHP Contract Section V.D.5 Provider Grievances and Appeals, j. HSO Grievances related to the Healthy Opportunities Pilot.*
        f) Adhere to the technology requirements described in *PHP Contract Section V.K. Technical Specifications, 8. Healthy Opportunities Pilot Technology Specifications.*
        g) If the Designated Pilot Care Management Entity is a Tier 3 AMH or CIN, it must participate in the Healthy Opportunities Pilot Care Management Payment Withhold outlined in this Contract and described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments***.** Designated Pilot Care Management Entities that are Local Health Departments are excluded from participation in the Healthy Opportunities Pilot Care Management Payment Withhold.
    ii. The PHP shall:
        a) Make Pilot care management payments including, as applicable, any amounts withheld as part of the Pilot Care Management Payment Withhold, to Designated Pilot Care Management Entities for Pilot-enrolled members as outlined in *Section III.D.32.e.iii. Pilot Care Management Payments*.
        b) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, PHP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.
    iii. The PHP shall include Department-developed standard contract language included in the Advanced Medical Home (AMH) Manual in its contracts with Designated Pilot Care Management Entities.
    iv. Healthy Opportunities Pilot Care Management Payment Withhold (Pilot Care Management Payment Withhold)
        a) The Pilot Care Management Payment Withhold is defined as a set

percentage of the monthly care management payment for which the Tier 3 AMH or CIN Delegated Pilot Care Management Entity, in partnership with the PHP and its PHP(s)' other Tier 3 AMH or CIN Delegated Pilot Care Management Entities, is required to meet specific performance target(s) described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* as a condition to receive the retained portion of the payment from the PHP.

b) The amount of the Pilot Care Management Payment Withhold shall be set at one percent (1%) of the monthly fixed Pilot care management payments made to the Tier 3 AMH or CIN Designated Pilot Care Management Entity by the PHP.

c) Within fifteen (15) Calendar Days of the PHP's receipt of the written notice of withhold from the Department described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* in advance of each performance period subject to a Pilot Care Management Payment Withhold, the PHP shall provide written notification to the Tier 3 AMH or CIN Designated Care Management Entity of the applicable performance period, details of the associated performance target(s) that is required to earn the retained funds, and the effective date that funds will start being withheld.

d) For the Tier 3 AMH or CIN Delegated Pilot Care Management Entity to receive the retained Pilot Care Management Payments, the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, shall meet the target during the applicable performance period subject to the withhold, in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments*.

e) Following the end of the applicable performance period and within thirty (30) Calendar Days of receipt of the notification of the determination of whether the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, met the performance target(s) during the performance period, the PHP shall notify the Tier 3 AMH or CIN Delegated Pilot Care Management Entity of the determination.

f) If a determination is made in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* that the targets have been met by the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, by the end of the applicable performance period, the PHP shall make a single, lump sum payment to the Tier 3 AMH or CIN Delegated Pilot Care Management Entity of the retained funds within sixty (60) Calendar Days of receipt of the funds from the Department.

g) If a determination is made in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* that the performance

target(s) have not been met by the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, by the end of the applicable performance period, the Tier 3 AMH or CIN Delegated Pilot Care Management Entity is not entitled to the retained funds.

dd. Healthy Opportunities Network Leads: The PHP must contract with any Healthy Opportunities Network Lead operating in the PHP's Region(s), as noted in Section V.D.1.c.vi, using a Department-standardized PHP-Network Lead model contract, to access the Network Lead's network of Pilot providers, also referred to as Human Service Organizations (HSOs).

ee. Advanced Medical Home InCK: For all Advanced Medical Homes participating in the InCK program, a provision that outlines the InCK model and requirements that is consistent with the Advanced Medical Home Manual. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's InCK Program.

ff. Category A and Category B Providers (as those terms are defined in 10A NCAC 27G .0602(8)): For all contracts with Category A or Category B providers, provisions that require compliance with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

2. Additional contract requirements are identified in the following Attachments:

a. Attachment M. 2. First Revised and Restated Advanced Medical Home Program Policy
b. Attachment M. 3. Pregnancy Management Program Policy
c. Attachment M. 4. Care Management for High-Risk Pregnancy Policy
d. Attachment M. 5. Care Management for At-Risk Children Policy
e. Advanced Medical Home Manual

3. All contracts between PHP and providers that are created or amended, must include the following provisions verbatim, except PHP may insert appropriate term(s), including pronouns, to refer to the PHP, the provider, the PHP/provider contract, or other terms and/or references to sections of the contract as needed and based upon context:

a. Compliance with State and Federal Laws
The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

b. Hold Member Harmless
The [Provider] agrees to hold the Member harmless for charges for any covered service. The [Provider] agrees not to bill a Member for medically necessary services covered by the Company so long as the Member is eligible for coverage.

c. Liability
The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents

or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].

d. Non-discrimination Equitable Treatment of Members

The [Provider] agrees to render Provider Services to Members with the same degree of care and skills as customarily provided to the [Provider's] patients who are not Members, according to generally accepted standards of medical practice. The [Provider] and [Company] agree that Members and non-Members should be treated equitably. The [Provider] agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender, or disability.

e. Department authority related to the Medicaid program

The [Provider] agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R.§ 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

f. Access to provider records

The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [PHP and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [PHP and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

i. *The United States Department of Health and Human Services or its designee;*
ii. *The Comptroller General of the United States or its designee;*
iii. *The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee;*
iv. *The Office of Inspector General;*
v. *North Carolina Department of Justice Medicaid Investigations Division;*
vi. *Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;*
vii. *The North Carolina Office of State Auditor, or its designee;*
viii. *A state or federal law enforcement agency; and*
ix. *And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.*

The [Provider] shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the NC Department of Health and Human Services.

Nothing in this [section] shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal

requirements for the submission of documentation in response to an audit or investigation.

g. *G.S. 58-3-225, Prompt claim payments under health benefit plans.*
Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, PHP shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The [Provider] shall submit all claims for a date of service on or before June 30, 2023, to the [Company] for processing and payments within one-hundred-eighty (180) Calendar Days from the date of covered service or discharge (whichever is later), except for pharmacy point of sale claims which shall be submitted within three-hundred sixty-five (365) Calendar Days of the date of the provision of care. When a Member is retroactively enrolled, the [Company] shall not limit the time in which claims may be submitted by the [Provider] to fewer than one hundred eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims and three hundred sixty-five (365) Calendar Days for pharmacy point of sale claims.

The [Provider] shall submit all claims with a date of service on or after July 1, 2023, to the [Company] for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service or discharge (whichever is later). When a Member is retroactively enrolled, the [Company] shall not limit the time in which claims may be submitted by the [Provider] to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider, health care provider facility, or pharmacy point of sale claims.

However, the [Provider's] failure to submit a claim within these timeframes will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

i. *For Medical claims (including behavioral health):*
    1. *The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the [Provider] whether the claim is clean, or pend the claim and request from the [Provider] all additional information needed to process the claim. The [Company] shall have the capability to request additional information via 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The [Company] shall implement the capability for EDI 277 and electronic method (portal or email) January 1, 2024, or later date if approved by the Department.*
    2. *The [Company] shall pay or deny a clean medical claim within thirty (30) Calendar Days of receipt of the clean claim.*

3. *A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.*

ii. *For Pharmacy Claims:*

1. *The [Company] shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.*
2. *A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.*

iii. *If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) Calendar Days of the notice requesting the required additional information, the [Company] shall deny the claim per § 58-3-225 (d).*

1. *The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest if applicable).*

iv. *If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest. Late Payments will bear interest on the portion of the claim payment that is late at the annual rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid.*

v. *The [Company] shall pay the interest as provided in this section and shall not require the [Provider] to request the interest.*

vii. *For purposes of claims payment, the [Company] shall be deemed to have paid the claim as of the Date of Payment, and the [Company] shall be deemed to have denied the claim as of the date the remittance advice is sent to the [Provider]. The [Company] defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to the [Provider] or the date a paper check is mailed to the [Provider].*

h. Contract Effective Date.

The contract shall at a minimum include the following in relation to the effective date of the contract.

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

i. Tobacco-Free Policy.

i. Providers who may Elect to Implement a Tobacco-Free Policy.

Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings, or manufacturing sites that employ adults who receive group day services, are not required to develop or maintain a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco- free policy.

ii. Providers Subject to a Partial Tobacco-Free Policy

Starting January 1, 2027, contracts with Intermediate care facilities for adults

with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings, the following policies shall be required:

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

1. *Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee.*
2. *Outdoor areas of the property, under [PROVIDER'S] control as owner or lessee shall:*
    a. *Ensure access to common outdoor space(s) free from exposure to tobacco use.*
    b. *Prohibit staff/employees from using tobacco products anywhere on the property.*

Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

iii. Providers subject to Full Tobacco-Free Policy

Starting January 1, 2027, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

[Provider] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on [Provider] from purchasing, accepting as donations, or distributing tobacco products to individuals [Provider] serves.

Attachment J. Ninth Revised and Restated Reporting Requirements

The following table details the Medicaid Managed Care Program reports that the PHP must submit to the Department. The PHP shall submit reports in the format, frequency and method that is defined in the NC PHP Report Guide. The NC PHP Report Guide provides guidance specific to each report. The Department shall maintain the NC PHP Report Guide, along with all applicable report templates, and publish to the PHP via the PHP Contract Data Utility (PCDU) with effective date. If a technical change is made to a template before the next NC PHP Report Guide version is published, a revised template will be posted to the PCDU with its new effective date. Each of the report templates contain specific data elements required, data definitions, and required formats.

Although the State has indicated the reports that are required, the PHP may suggest additional reports.

1. As part of Readiness Activities, the PHP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
2. The Department reserves the right to require additional reports beyond what is included in this Attachment, which shall be added by Amendment. The PHP shall submit all report formats to the Department for approval. Reports require approval by the Department before being considered final.

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
1. ***Administration and Management***	
a. PHP Operating Report	Annual report of each entity identified under the PHP Operating Report, providing evidence of PHP oversight activities and entity performance (i.e. metrics, CAPs, sanctions)
2. ***Members***	
a. PHP Enrollment Extract	Weekly detail and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
b. Member Services Quality Assurance Report	Quarterly report of survey results which measures member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
c. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.
d. Reserved.	
e. Reserved.	
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
g. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PHP including the total number of appeal and grievance requests filed with the PHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.
h. PHP Enrollment Summary Report	Monthly summary report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
i. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).
j. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report of non-verifiable Member addresses and returned mail.
k. Nursing Facility Admission Disenrollment Report	Ad hoc report on Member disenrollment from a PHP due to a Nursing Facility stay longer than 90 days.
l. Clearinghouse Daily Uploads Extract	Tracking file submitted for each daily or weekly upload to the PCG Clearinghouse of each initial Notice of Adverse Benefit Determination (NABD) and Resolution Notice of Adverse Benefit Determination sent to members.
m. Monthly PHP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems.
n. Reserved.	
3. ***Benefits and Care Management***	
a. Institute of Mental Disease (IMD) Report	Every other week summary of members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.
b. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides summary information on pharmacy prior approval requests.
c. ProDUR Alert Report	Quarterly report highlighting prospective alerts and responses for pharmacy claims.
d. Top GSNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.
e. Ad Hoc and Trigger Report	Quarterly report containing activities and ad hoc report, summary of total paid claims, and trigger report with comparison of top 200 GC3s by claim count.
f. EPSDT Report	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.
g. Non-Emergency Medical Transportation (NEMT) Report	Monthly report highlighting the NEMT utilization, monthly requests received, processed, denied and open where the date of service falls within the reporting range.

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
h. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.
i. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Programs.
j. Enhanced Case Management Pilot Report	Quarterly report of Members served, services used, total costs related to Enhanced Case Management pilots.
k. CMARC and CMHRP Corrective Action Plan Report	Quarterly report on Care Management for At-Risk Children & and Care Management for High- Risk Pregnancy report on corrective action plan and the associated decision reasoning.
l. Care Needs Screening Report	Quarterly report of beneficiary screening results including SDOH and Care Needs Screening.
m. Reserved.	
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. Reserved.	
p. Nursing Facility Transitions Report	Quarterly report tracking the number and disposition of Members discharged from a nursing facility.
q. Ongoing Transitions of Care Status Report	Monthly report to provide a status update of PHP's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFP and the Department's Transitions of Care policy.
r. Reserved.	
s. Reserved.	
t. Reserved.	
u. Service Line Issue Summary Report	Quarterly report to identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.
v. Medical Prior Authorization Extract	Weekly detail data extract of medical prior authorizations.
w. Pharmacy Prior Authorization Extract	Weekly detail data extract of pharmacy prior authorizations.
x. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.
y. UM and Clinical Coverage Report	Ad Hoc report outlining analysis of compliance with attestation upon request.

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
z. PCP Operational Monitoring Report	Monthly report on PCP assignment, changes and panel limits.
aa. Clinically Integrated Networks (CIN) Contracting Report	Monthly report that identifies contracting status between the PHP and Clinically Integrated Networks (CIN) and their affiliated AMH Tier 3 practices.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Reserved.	[redacted]
c. Reserved.	
d. Reserved.	
e. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Reserved.	[redacted]
g. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.
h. Network Adequacy Annual Submission Report	Annual and Ad hoc report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
i. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
j. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. To be submitted with the Timely Access Physical Health Provider Appointment Wait Times Report.
k. Reserved.	[redacted]
l. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. To be submitted with the Timely Access Behavioral Health Provider Appointment Wait Times Report.
m. Reserved	[redacted]
n. Provider Grievances, and Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
o. FQHC RHC Summary Remittance Advice Report	Quarterly report for FQHC/RHC claims data used to enable wrap payments.
p. Local Health Department Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.
q. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Public Ambulance Provider directed payments.
r. Reserved.	
s. Out of Network (OON) Service Requests Report	Monthly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning
t. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).
u. Summary UNC_ECU Physician Claims Report	Quarterly report to capture claims data to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.
v. NEMT Provider Contracting Report	Quarterly report to capture non-emergency provider contracting report at a detailed and summary level from the PHP's.
w. Capitation Reconciliation Report	Monthly report that PHPs will leverage the to inform the State of any capitation related payment discrepancies observed. PHPs will include records of beneficiaries where no payment was received from the State or payment received differed from the amount expected. PHPs will only include beneficiary records with discrepancies on this report to the State. The PHP Capitation Reconciliation Report will be submitted on a monthly cadence. PHPs will indicate expected values and values observed on ASC x12 834 monthly file for beneficiaries.
x. Reserved.	
y. Reserved.	
z. Reserved.	
5. ***Quality and Value***	
a. Reserved.	
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved	
d. Reserved	
e. Reserved	

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
g. Eligible Mothers for Low Birth Weight Extract	Quarterly update on eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.
6. ***Stakeholder engagement***	
a. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes incl. number served.
b. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PHP to collaborate with county organizations to address issues by county/region.
7. ***Program Administration***	
a. Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.
b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).
d. Reserved.	
8. ***Compliance***	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.
b. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
c. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by provider including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
d. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Overpayment Recoveries Report	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).
f. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
g. Reserved.	
h. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	Quarterly report to record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP. (Section IV.4.d.)
i. Recipient Explanation of Medical Benefit (REOMB) Report	The PHP is responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The PHP sends REOMBs to a random sample of Members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the Member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The PHP is required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.
9. ***Financial Requirements***	
a. NC PHP Financial Report	A consolidated reporting packet of all finance related reporting requirements. Specific submission instructions and details are located in the associated companion guide with the report template. Audited Financial Statements submitted as part of this reporting packet must comply with 42 C.F.R. § 438.3(m).
b. Financial Arrangements with Drug Companies Report	Bi-annual report that describes all financial terms and arrangements between the PHP and any pharmaceutical drug manufacturer or distributor.
c. Risk Corridor Service Ratio Report	Interim, Preliminary and Final Risk Corridor Service Ratio reports providing information on the components of the Risk Corridor Service Ratio and Primary Care Expenditure Percentage requirements.
d. NC PHP Claims Monitoring Report	Monthly summary of the volume and dollar amount of claims that were paid, denied, and rejected during the reporting period, and current inventory of pended claims by professional, institutional, and pharmacy. Top 10 denial reasons by volume and dollar amount.
e. TPL Recovery Match Report	A monthly report detailing those claims upon which the PHP has been unable to effectuate recovery within one (1) year of the date of service.
10. *Healthy Opportunities Pilot*	
a. Reserved.	
b. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PHP may submit if the Department notifies the PHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PHP's anticipated spending through the remainder of the Pilot service delivery year.

Ninth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
c. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.
d. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PHP Pilot administrative fund spending.
e. Healthy Opportunities Pilot Care Management Assignment Report	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Pilot Enrolled Beneficiaries.
f. Healthy Opportunities Pilot High-Priority Populations Report	Report that the PHP will submit in dual parts: (a) annually, the PHP will submit the Priority Populations Report outlining the PHP's plan for enrolling priority populations, to understand the PHP's enrollment plans and ensure inclusive representation of priority populations. (b) quarterly, the PHP will submit the report outlining aggregate enrollment data for these priority populations, to understand the PHP's progress towards meeting target enrollment as outlined in the Priority Populations Report (a).

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Attachment M.10. Third Revised and Restated Approved <Plan Name> In Lieu of Services

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the Medicaid or NC Health Choice State Plans or otherwise covered by this Contract but have been determined by the Department to be medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.

The PHP may cover for Members, services or settings that are in lieu of services or settings covered under the State Plans as follows:

1. The Department determines that the alternative service or setting is a medically appropriate and cost-effective substitute based on documentation provided to the Department by the PHP demonstrating such cost effectiveness and clinical effectiveness;
2. The PHP shall ensure that Members are provided the rights outlined in *Section V.C.1.g. In Lieu of Services* for all approved In Lieu of Services;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the PHP; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise. In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process.

In accordance with *Section V.C. Benefits and Care Management*, the following In Lieu of Services have been approved by the Department:

Attachment M.10. Third Revised and Restated Approved AmeriHealth Caritas of North Carolina In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Institute for Mental Disease (IMD) for Mental Health Services for Members 21-64	Use of IMD settings for Members in need of psychiatric care provides the needed level of care and supervision for these adults while avoiding a more costly admission in an inpatient psychiatric unit. The added benefit is leaving the inpatient psychiatric bed open for individuals who need that level of care, and thereby reducing the incidence of Members in need of an inpatient psychiatric admission waiting for prolonged periods in the emergency room.	Mental Health IP-Acute Inpatient Hospital	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160
Behavioral Health Urgent Care (BHUC)	A BHUC is an alternative, but not a replacement, to a community hospital Emergency Department (ED). Members receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care.	Emergency Department-Acute Inpatient Hospital	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co- occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. (Episode of Care) Per Person 1-Unit/1-2 days.	T2016 U5

Attachment M.10. Third Revised and Restated Approved Blue Cross and Blue Shield of North Carolina In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Institute for Mental Disease (IMD) for Mental Health Services for Members 22-64	IMD hospital treatment in a hospital setting twentyfour (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide alternative placement for treatment for beneficiaries with acute psychiatric for no more than fifteen (15) Calendar Days within a calendar month.	Inpatient Psychiatric bed Facility	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160
Behavioral Health Urgent Care (BHUC)	Diversion from Inpatient hospitalizations and long wait times/observation in emergency rooms for placement. Stabilization of condition and ability to return to community.	Emergency Room Observation Inpatient Acute Hospitalization	Target Population includes members, aged 4 and older experiencing a BH crisis, psychological, or biological dysfunction and functional impairment, which are consistent and associated with DSM-5 diagnosis. (Episode of Care) 1 Unit=Per Diem per 1-Day.	T2016 U5

Attachment M.10. Third Revised and Restated Approved Carolina Complete Health In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Massage Therapy	Alternative pain management via message therapy provided by a licensed practitioner in Lieu of pharmaceutical pain management with Schedule II narcotics. Reduction in chronic pain and back pain without the use of opiate therapies.	Injection, Hydromorphone Injection, methadone HCl Injection, meperidine hydrochloride Injection, fentanyl citrate Codeine phosphate	Target Population includes adult members that have documented history of chronic pain (Episode of Care) One Unit=15 minutes/ 40 per fiscal year	97124, 97140
Institute for Mental Disease (IMD) for Mental Health Services for Members 22-64	Use of IMD settings for Members in need of psychiatric care provides the needed level of care and supervision for these adults while avoiding a more costly admission in an inpatient psychiatric unit. The added benefit is leaving the inpatient psychiatric bed open for individuals who need that level of care, and thereby reducing the incidence of Members in need of an inpatient psychiatric admission waiting for prolonged periods in the emergency room.	Inpatient Hospital	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160

Behavioral Health Urgent Care (BHUC)	BHUC offers a safe alternative and diversion from the use of hospital emergency departments to address the needs of Members experiencing behavioral health crises. A BHUC is a service containing Triage, Crisis Assessment, Interventions, Disposition and Discharge Planning with the goal to reduce inappropriate utilization of the Emergency Department for BH specific needs and assisting Members by linking them to more clinically appropriate community based services and decreasing the recurrence of crisis needs.	Emergency Care Inpatient Hospital	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co- occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. (Episode of Care) Per Person 1 unit/Per event	T2016 U5 (without Observation) T2016 U8 (with Observation)

Attachment M.10. Third Revised and Restated Approved United Healthcare of North Carolina In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Behavioral Health Urgent Care (BHUC)	A designated intervention/treatment location, known as a BHUC, that is an alternative to any community hospital emergency department where members with urgent primary behavioral health needs will receive triage and referral. The behavioral health urgent care location must include the ability to initiate the involuntary commitment petition via first-level evaluations (Clinician Petition), medical screening, case management and referrals.	Inpatient Hospital	Target Population includes children aged 4 to 20 and adults with mental health, substance use disorder, or co-occurring disorders. Also, people experiencing behavioral health crisis meeting urgent triage standards. (Episode of Care) Per Person 1-Unit per Diem	T2016 U5
Institute for Mental Disease (IMD) for Acute Psychiatric Care	Increasing access to IMD acute beds for Members in behavioral health crisis can lead to better outcomes and fewer exacerbations of serious behavioral health crises. Use of IMD beds, in conjunction with other diversion based length of stay (BHUC where	Inpatient Hospital	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior,	0160

	available), along with robust Care Management and ancillary supports such as Peer Support will help to ensure Members have access to the right care at the right time for their specific needs – as well as for well-managed lengths of stay		potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	

Attachment M.10. Third Revised and Restated Approved WellCare of North Carolina In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Intensive Outpatient (IOP) for Mental Health	IOPs are more cost effective than hospitalization while delivering invaluable group therapy in a setting of supportive professional care, including peer support by those with lived experience to support positive change. Group-based therapy offers Members an opportunity to participate in a community setting to witness the success of those around them and inspire others within the group as they further their own therapy, knowledge of their psychiatric conditions and steps toward sustained recovery. IOPs for treatment of mental health conditions offer services and support programs that operate on a small scale and do not require the intensity associated with hospitalization or residential services characteristic of larger, broader-based treatment centers	Partial Hospitalization	Target Population includes members with a behavioral health diagnosis needing more intensive care, but not inpatient treatment; members discharging from inpatient care who need more than outpatient support. The duration of service is per diem, 4-hours per day, 4-5 days per week, with length of service 4-6 months.	S9480 with Rev Code 905

Institute for Mental Disease (IMD) for Acute Psychiatric care	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members ages 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to fifteen (15) Calendar Days per calendar month in an IMD.	Inpatient Stay-Initial Hospital Care	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160
Behavioral Health Urgent Care (BHUC)	Provide crisis stabilization for Members experiencing acute mental health episodes in an urgent care setting in order to decreased crisis/emergency department utilization, decrease inpatient hospital stays, and improve crisis stabilization.	Emergency Room Visit Inpatient Stay-Initial Hospital Care	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co- occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. The duration of service is per 1 unit per event (2 hours per episode)	T2016 U5
Specialized Therapeutic In-Home Service Programs for High Risk Populations	Specialized therapeutic in-home service is a flexible in home support service designed for children at risk of foster care, ages 5 through 17, who are at risk for or stepping down from	Inpatient Hospital Stay	Target Population includes beneficiaries with complex medical and behavioral health conditions and unmet social needs. The duration of service is 1 visit per diem (max 1 day per week) Based	H0046 HK

	inpatient services. Services are delivered by a team led by a licensed clinician and a targeted case manager, a Master's-level therapist, and a psychiatric nurse as a means to decreased inpatient and crisis utilization and decrease crisis/emergency department utilization		on Medical necessity up to 120 days.	

Attachment M.14. Second Revised and Restated Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards

All capitalized terms used in this Attachment not otherwise defined herein shall have the meanings ascribed to them as set forth in the Contract.

1. Access to IPV-Related Information
   a. The PHP shall consider any authorizations, Services, data, information, reports, invoices, or other sources of information relating to or referencing IPV-Related Services authorized to be furnished to a Member or actually furnished to a Member as "*IPV-Related Service Data*."
   b. The PHP shall ensure that all members of the PHP's workforce (which term, as used in this Attachment, includes PHP's employees and contractors) with access to Pilot-related data, including data from NCCARE360, complete IPV-Related Data Training before working with such data, including :
      i. IPV-Related Services;
      ii. Handling of, privacy of, security of, and access to IPV-Related Service Data;
      iii. All such other trainings as required by the Contract and by the Department in its sole discretion. The Department shall provide at least ninety (90) Calendar days notice of any changes to the Healthy Opportunities Pilot IPV Protocol.
   c. Upon a PHP workforce member's completion of such trainings, the PHP may designate such individual as an "*IPV-Trained Individual*."
   d. The PHP shall keep current records of each IPV-Trained Individual's completion of IPV-Related Data Training for as long as such IPV-Trained Individual is employed or contracted by the PHP and, following termination or expiration of such individual's employment or contract, for the greater of any period of time as required by applicable law or one (1) year following such termination or expiration.
   e. The PHP shall ensure that only IPV-Trained Individuals are authorized to access and view IPV-Related Service Data. The PHP shall ensure that any PHP workforce member or Care Manager who is not an IPV-Trained Individual does not have authorization to access and may not access any IPV-Related Service Data.

2. IPV-Related Data Standards
   a. The PHP agrees to conduct routine and ongoing monitoring of IPV-Related Service Data, which monitoring shall include at a minimum:
      i. Reserved.
      ii. internal auditing of the PHP's adherence to the IPV-Related Data Policies (as referenced in Section 6 of this Attachment and reporting to the Department on the same, such auditing and reporting each occurring no less than annually or as frequently as otherwise directed by the Department in its sole discretion;
      iii. reporting to the Department within the timeframes specified in *Section III.E.11. Privacy and Security Incidents and Breaches* of identifying any incident or breaches of IPV-Related Service Data in the custody of or maintained by the PHP or its contractors; and

iv. reporting to the Department within one (1) Business Day upon identification of any material non-compliance with any of the PHP's IPV-Related Data Policies.

b. In the event that the PHP discovers an incident or breach of IPV-Related Service Data, the PHP shall send written notice to each Care Manager within one (1) Business Day (as defined in Section 3 of this Attachment and HSO whose IPV-Related Service Data was or may have been affected by the incident or breach, informing the Care Manager and HSO of the nature and extent of the unauthorized access or breach, and providing the Care Manager and HSO with a list of Members whose data was or may have been affected by the unauthorized access or breach.

c. The PHP shall ensure that all of its PHP workforce members and Care Managers who have Healthy Opportunities Pilot responsibilities complete required Pilot-related training on privacy, security, and access controls related to IPV-Related Service Data and on relevant PHP policies and procedures relating to usage, storage and sharing of IPV-Related Service Data, including but not limited to the PHP's IPV-Related Data Policies (as referenced in Section 6 of this Attachment) prior to IPV service launch and annually thereafter.

3. Care Manager Training
   a. The PHP shall ensure that Care Managers with Healthy Opportunities Pilot responsibilities are designated as IPV-Trained Individuals and receive and complete relevant trainings annually, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment , including but not limited to the below trainings:
      i. IPV-Related Data Training;
      ii. Working with IPV survivors;
      iii. Trauma-informed care delivery;
      iv. Cultural Humility and/or Competency training;
      v. The Healthy Opportunities Pilot consent process, including how to communicate to Members that while an initial Pilot consent is obtained by the Care Manager, HSOs may request that the Member execute additional consents depending on the services the HSO furnishes to the Member or the services that the Member may be eligible to access or receive.

4. Health Opportunities Pilot Enrollee Contact Preferences
   The PHP shall ensure that:
   a. When obtaining and recording a Member's contact preferences pursuant to *Section V.C.8.g.xxxv Healthy Opportunities Pilot Enrollee Communication Requirements* of the Contract, and such Member is authorized to receive, has received, or is currently receiving IPV-Related Services, Care Managers shall adhere to Department standard's as defined in the IPV-Related Data Training with respect to the level of specificity in recording Member contact requirements as provided for in the Care Manager IPV-Related Trainings.

5. Member Opt-In/Opt-Out Requirements
   a. In all communications with Members who are authorized to receive, have received, or are currently receiving IPV-Related Services, the PHP shall, and shall cause Care Managers and individuals in the PHP's workforce to, properly consider IPV survivor safety guidelines as set forth in the IPV-Related Data Training and the Care Manager IPV-Related Trainings.

b. The PHP shall ensure that no member-facing materials targeting individuals who may be, or are currently, experiencing IPV are distributed without Department review and approval.

c. When communicating with a Member pursuant to *Section V.C.8.g.xxxv Healthy Opportunities Pilot Enrollee Communication Requirements o*f the Contract and the Member in question is authorized to receive, has received, or is currently receiving IPV-Related Services, Care Managers and individuals in the PHP's workforce may send such communications only if adhering to the requirements set forth in Section 4 of this Attachment and taking all care necessary as directed by the Care Manager IPV-Related Trainings.

6. IPV-Related Policies and Enforcement

The PHP shall develop a Healthy Opportunities Pilot Interpersonal Violence (IPV) Related Services Policy (IPV Policy) for review by the Department by March 15, 2023, and at the Department's request. The IPV Policy shall include all of the requirements of the PHP as defined in the Contract.

Attachment M.16. Tribal Payment Policy

1. **Background**
   This Tribal Payment Policy outlines the expectations of the Department regarding payment for covered services to Indian Health Care Providers (IHCP) by a PHP. Indian Health Care Provider (IHCP) refers to a "health care program" operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by State-recognized Tribes are not considered IHCPs. In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a "Tribal Provider Attestation." This "Tribal Provider Attestation" letter from the EBCI Chief's office shall be submitted to the Department as part of the Department's centralized credentialing process. The information about Tribal providers will be shared with the PHP through the Department's existing process.

2. **Scope**
   This Policy applies to the PHP and covers payment for covered services provided by IHCPs and other Tribal providers. This Policy shall apply to all IHCPs/Tribal providers regardless of the provider's contracting status.

3. **Policy Statement**
   The PHP shall implement the Tribal Payment Policy described below by developing and maintaining a written Tribal Payment Policy relating to all IHCPs/Tribal providers regardless of the provider's contracting status consistent with the Department's Tribal Payment Policy.
   a. Claim Submission
      i. Cherokee Indian Hospital (CIHA) will bill for inpatient and outpatient services and will be paid for these services in accordance with current NC Medicaid requirements.
      ii. Other Indian Health Service (IHS)/Tribal/Urban (I/T/U) providers/Tribal providers will submit claims utilizing formats currently utilized when billing NC Tracks in Medicaid Fee-for-Service.
   b. Payment
      i. Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the Office of Management and Budget (OMB) rate, for applicate AIR services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. The PHP shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with the PHP shall continue to follow those arrangements. OMB tribal rates for hospital inpatient and outpatient services are included and identified on the hospital fee schedule available on the Fee Schedule and Covered Codes Portal.
         1. If a Member seeks care at an Indian health provider out-of-state, the services to the Member should be reimbursed by the OMB rate, if applicable.
      ii. To promote same day access and reduce barriers or burdens to a Member such as transportation or taking time off from work, providers receiving the AIR rate may receive encounters per day (single day of service) such as but not limited to follows:
         1. Medical;
         2. Dental;
         3. Behavioral; and
         4. One (1) other such as optical.

iii. The PHP shall reimburse I/T/U pharmacies for pharmacy claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan (a maximum of two (2) pharmacy AIR per patient per day):
    1. High-Cost Drugs are excluded and are paid based on the Department's outpatient pharmacy 'lessor of logic'.
    2. If more than two (2) drugs are filled, additional drugs beyond the two (2) will be paid at zero dollars ($0) and should be used by the PHP for medication reconciliation.
    3. The Pharmacy Point of Sale OMB encounter rate (ER) fee schedule is found on the fee schedule and covered codes portal. The fee schedule name is Indian Tribal (I/T/U) Pharmacy fee schedule.
    4. There is no Tribal OMB rate for Ambulatory Surgical Center services. The PHP should follow the Ambulatory Surgical Center Fee Schedule available on the Fee Schedule and Covered Codes portal.

iv. Tribal entity claims will not add up to the AIR rate since the AIR rate is established for all federally recognized Tribes. NC Medicaid adopted the AIR (also known as the OMB rate) as the rate to be used for the reimbursement of services provided by CIHA.

v. The PHP shall comply with *PHP Contract Section V.D.4.h. Indian Health Care Provider (IHCP) Payments*.
    1. In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the PHP shall reimburse IHCPs as follows:
        a) Those that are not enrolled as an FQHC, regardless of whether they participate in the PHP's network:
            i) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
            ii) The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.
        b) Those that are enrolled as FQHCs, but do not participate in the PHP's network, an amount equal to the amount the PHP would pay a network FQHC that is not an IHCP.
    2. The PHP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
    3. The Indian Tribal (I/T/U) Home Health Fee schedule is posted on the fee schedule and covered codes portal and specific to just the Tribe codes and rates.
    4. The Skilled Nursing Facility Fee schedule is posted on the fee schedule and covered codes portal and specific to just the Tribe codes and rates.

vi. The PHP shall comply with *PHP Contract Section V.F.1. Engagement with Federally Recognized Tribes* with regard to providing and maintaining a point of contact for IHCP billing issues to the Department.
    1. The PHP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

vii. Ambulatory Surgical:
    1. All procedures billed that fall under one thousand dollars ($1000) will be billed at the Outpatient OMB Rate.
    2. All procedures that are one thousand dollars ($1000) and above will be billed at the Medicaid Fee Schedule.

viii. All non-OMB rates for Tribal payment follows the regular Medicaid Fee-for-Service methodology and fee schedules for the PHP, unless otherwise defined in the Tribal Payment Policy.

c. Prompt Pay
   i. The PHP shall comply with *PHP Contract Section V.H.1.d., Prompt Payment Standards*.
      1. The PHP shall promptly pay Clean Claims, regardless of provider contracting status. The PHP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.
         a) Medical Claims
            i) The PHP shall, within eighteen (18) Calendar days of receiving a Medical claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.
            ii) The PHP shall pay or deny a Clean Medical Claim within thirty (30) Calendar Days of receipt of the claim.
            iii) A Medical Pended Claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
         b) Pharmacy Claims
            i) The PHP shall within fourteen (14) Calendar Days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim.
            ii) A Pharmacy Pended Claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.
         c) If the requested additional information on a Medical or Pharmacy Pended Claim is not submitted within ninety (90) Calendar Days of the notice requesting the required additional information, the PHP may deny the claim in accordance with NCGS § 58-3-225(d).
         d) For purposes of claims payment, the PHP shall be deemed to have paid the claim as of the Date of Payment, and the PHP shall be deemed to have denied the claim as of the date the remittance advice is sent.
      2. The PHP shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).
      3. Claim Submission Timeframes:
         a) For any claims with a date of services on or before June 30, 2023:
            i) Pursuant to NCGS § 58-3-225(f), the PHP may require that claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the Member's discharge from the facility. However, the PHP may not limit the time in which health care provider and health care facility claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.
            ii) The PHP may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member for pharmacy point of sale claims and may not limit the time to fewer than three hundred sixty-five (365) Calendar Days.
            iii) When a Member is retroactively enrolled, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from

the date of enrollment for health care provider and health care provider facility claims and three hundred sixty-five (365) Calendar Days for pharmacy point of sale claims.

iv) When a claim requires financial eligibility determination, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date the patient monthly liability (PML) is determined.

b) For any claims with a date of service on or after July 1, 2023:

i) Consistent with NCGS § 58-3-225(f), the PHP may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within three hundred sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. However, the PHP may not limit the time in which health care provider and health care facility claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days. Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

ii) When a Member is retroactively enrolled, the PHP may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment.

iii) When a claim requires financial eligibility determination, the PHP may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date the patient monthly liability (PML) is determined.

c) For a secondary claim from a third-party commercial or Medicare insurance regardless of the date of service on the claim, the PHP shall allow the Provider one hundred eighty (180) Calendar Days from the primary insurer's Explanation of Benefits/Remittance Advice date (whether the claim was paid or denied) to file the claim to the Member's assigned PHP. The claim should be submitted electronically, and a copy of the third-party commercial or Medicare insurance EOB/RA should be uploaded as an attachment.

4. Interest

a) The PHP shall pay interest to the Provider on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract.

b) The PHP shall not be subject to interest payments under circumstances specified in NCGS § 58-3-225(k).

5. The PHP shall maintain written or electronic records of its activities under this Section in accordance with NCGS § 58-3-225(i).

6. For purposes of actions which must be taken by a PHP as found in *PHP Contract Section V.H.1.d. Prompt Pay Standards*, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

d. Other Payment Sources

i. Due to the change in payer hierarchy, the PHP will allow for timely payment for Tribal providers without delaying payments due to coordination of benefits. Medicare and

Medicaid are payers of first resort for Tribal members and providers. Tribal and IHS funds are payers of last resort.

ii. Tribal self-funded insurance is not a billable source for the Eastern Band of Cherokee Indians (EBCI), and therefore, the PHP shall not attempt to coordinate benefits with that plan.

e. Sovereignty

i. No contractual relationship shall deny or alter Tribal sovereignty.

Attachment N. Reserved