Amendment Number 1
Contract #30-2022-007-DHB-#
Medicaid Direct Prepaid Inpatient Health Plan Contract

THIS Amendment to Contract #30-2022-007-DHB-#(Contract), is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and *PIHP Name* (Contractor), each, a Party and collectively, the Parties.

Background:
North Carolina will launch the NC Medicaid Managed Care Medicaid Direct Prepaid Inpatient Health Plan April 1, 2023. This plan is North Carolina's behavioral health, substance use disorder, and I/DD program for Medicaid beneficiaries who are not enrolled in Managed Care. The population eligible to receive services through Medicaid Direct include CAP/C and CAP DA waiver, full Medicaid/Medicare duals, Innovations Waiver for Tribal members only and other excluded populations. Other Excluded population include the medically needy, individuals enrolled in the health insurance payment program (HIPP), residents in long-term care nursing facilities and those with limited benefits. Additionally, Foster Care, adoptions, and youth formerly in the Foster Care system will be included in Medicaid Direct until the Children and Family Specialty Plan launches. Medicaid Direct eligible beneficiaries will receive physical health and pharmacy services from the State through the fee for service program.

The purpose of this Amendment is to modify existing requirements and incorporate new requirements to the Contract.

The Parties agree as follows:

1. Modifications to Section II. Definitions and Abbreviations

Specific subsections are modified as stated herein.

a. *Section II. A. Definitions.* The following defined terms are revised and restated as identified herein.

4. **Adverse Benefit Determination:** Has the same meaning as Adverse Benefit Determination as defined in 42 C.F.R. § 438.400. Any decision to deny, reduce, suspend, or terminate waiver participation or requests for or placement on the Registry of Unmet Needs are considered Adverse Benefit Determinations consistent with the definition at 42 C.F.R. 438.400.

8. **Appeal:** As relates to Members, has the same meaning as Appeal as defined in 42 CFR § 438.400(b).

16. **Beneficiary:** An individual who is enrolled in the North Carolina Medicaid program but who may or may not be enrolled in the Medicaid Managed Care program.

31. **Reserved.**

42. **Clean Claim:** A Claim submitted to a PIHP by a service provider that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is suspended, under investigation for fraud or abuse, or a claim under review for medical necessity. 42 C.F.R. § 447.45(b). Determination of whether a claim is a "clean claim," rests with the Contractor and must be determined for each claim, provided applied consistently and reasonably. 85 FR 72754, 72819.

53. **Contract Year:** As specified in *Section III.A.*, the period beginning with when the PIHP begins providing services under this Contract for Years 1 – 4 as indicated below:
    a. Contract Year 1: April 1, 2023 through June 30, 2024
    b. Contract Year 2: July 1, 2024 through June 30, 2025
    c. Contract Year 3: July 1, 2025 through June 30, 2026
    d. Contract Year 4: July 1, 2026 through March 31, 2027

56. **Cross-over Population**: Refers to North Carolina Medicaid beneficiaries that are enrolled in the NC Medicaid Direct program and will transition to Medicaid Managed Care at a specific date determined by the Department.

71. **Enrollment:** The process through which a Beneficiary selects or is auto-enrolled to a Standard Plan, BH I/DD Tailored Plan, Medicaid Direct PIHP, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid benefits through the Medicaid Managed Care program.

77. **Fee-for-Service:** A payment model in which Providers are paid for each service provided. NC Medicaid's Fee-for-Service program is also known as NC Medicaid Direct.

90. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a). In North Carolina, an IHCP is a provider of service which includes all services that Cherokee Indian Hospital Authority or the Eastern Band of Cherokee Indians offer under Medicaid.

97. **Reserved.**

108. **Medicaid Managed Care:** North Carolina's program under which contracted Managed Care Organizations arrange for integrated medical, physical, pharmacy, behavioral and other services to be delivered to Medicaid enrollees. Medicaid Managed Care will include three types of plans: (1) Standard Plans, (2) BH I/DD Tailored Plans, and (3) Statewide Foster Care Plan. The use of Medicaid Managed Care is also inclusive of EBCI Tribal Option, operating as a primary care case management entity (PCCMe).

111. **Members:** Medicaid Beneficiaries specifically enrolled in and receiving benefits through the PIHP.

119. **NCTracks:** The Department's multi-payer Medicaid Management Information System (MMIS). NCTracks adjudicates claims for multiple NC DHHS divisions, including DHB, DMH/DD/SAS, Division of Public Health, and Office of Rural Health. NCTracks also serves as a central repository for Medicaid, NC Health Choice and State-funded Services Provider and Member data**.**

124. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department's integrated case management system that provides eligibility and enrollment for Medicaid, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.

125. **Reserved.**

142. **Potential Member**: A Beneficiary enrolled in Medicaid and eligible for enrollment in a PIHP, but not enrolled in that PIHP.

150. **Provider Enrollment:** The process by which a Provider is enrolled in North Carolina's Medicaid program, with credentialing as a component of enrollment. A Provider enrolled in North Carolina's Medicaid program~~s~~ (or both) shall be referred to as a "Medicaid Enrolled Provider" or an "Enrolled Medicaid Provider."

152. **Provider Support Service Line:** A service line available to Medicaid Providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries, and complaints.

160. **Redeterminations:** The annual review of Beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid.

165. **Settlement Agreement:** Means the court-enforceable Settlement Agreement between the United States and the State of North Carolina filed with the United States District Court for the Eastern District of North Carolina on August 23, 2012, and modified in October 2017 and which created the Transition to Community Living (TCL) program.

b. *Section II. A. Definitions.* The following defined terms incorporated as identified herein.

190. **1915(i) Services:** The Section 1915(i) SPA - Home and Community-Based Services (HCBS) for eligible members that the PIHP offers in the geographic area covered by this Contract.

191. **Episode of Care:** A treatment or intervention covered under the Tailored Plan benefit, initiated prior to NC Medicaid Managed Care Tailored Plan Launch and evidenced by a current treatment plan, which is related to a Member's condition or circumstance and is provided to the Member by the non-participating provider within the first 60 days after Tailored Plan Launch.

192. **Facility:** Has the same meaning as Facility in N.C. Gen. Stat. §122C—3(14).

193. **Independent Assessment:** Required assessment of needs used to establish a service plan for 1915(i) services. 42 CFR § 441.720.

194. **Independent Evaluation:** Required evaluation used to determine eligibility for 1915(i) services. The Department shall provide a standardized tool to be used for the required independent evaluation. 42 CFR § 441.715(d).

195. **Indian Managed Care Entity (IMCE)**: Means an ICME as defined by 42 C.F.R. § 438.14(a). In North Carolina, the IMCE is referred to as the Eastern Band of Cherokee Indian Tribal Option. It provides care management for all members enrolled in Tribal Option and is separate from the Indian Health Care Provider.

196. **Medicaid Direct Prepaid Inpatient Health Plan:** Refers to the benefit plan operated by a PIHP under contract with the Department, as recognized as contract number 30-2022-007-DHB.

197. **Service Organization Control:** Reports on various organizational controls related to security, availability, processing integrity, confidentiality or privacy.

198. **Transition Entity:** Department-designated entity responsible for coordinating transition of care activities and supporting members through the transition between service delivery systems. Transition entities include BH I/DD Tailored Plans, other Tailored Plans, CCNC, Tribal Option and other designated entities.

199. **Transition Notice Date:** The date a transitioning member's anticipated enrollment change is reflected on the Tailored Plan's eligibility file.

200. **Work Hour:** Includes each traditional work hour of a Business Day.

c. *Section III. B. Abbreviations and Acronyms.* The following acronyms are modified or new and incorporated into the Contract:

i. Modified Acronyms:

38. Reserved
126. Reserved
151. Reserved
182. PIP: Performance Improvement Project
190. QAPI: Quality Assessment and Performance Improvement

ii. New Acronyms:

234. ACGME: Accreditation Council for Graduate Medical Education
235. ANSA: Adult Needs and Strengths Assessment
236. IDM Tool: Informed Decision Making Tool
237. PHE: Public Health Emergency
238. TCM: Tailored Care Management

2. Modifications to Section III. Contract Term, General Terms and Conditions, Protections, and Attachments

Specific subsections are modified as stated herein.

a. *Section III. A. Contract Term and Service Commencement* is revised and restated as follows:

Contract Term and Service Commencement

The Contract is effective upon execution through March 31, 2027, or as otherwise provided by law, and shall include an implementation period and Contract Years 1 through 4 as follows:

Contract Period	Upon execution through March 31, 2027
Implementation Period	Upon execution through March 31, 2023
Contract Year 1	April 1, 2023 through June 30, 2024
Contract Year 2	July 1, 2024 through June 30, 2025
Contract Year 3	July 1, 2025 through June 30, 2026
Contract Year 4	July 1, 2026 through March 31, 2027

b. *Section III. B. General Terms and Conditions,* ***29. MEDIA CONTACT APPROVAL AND DISCLOSURE:*** is revised and restated as follows:

29. MEDIA CONTACT APPROVAL AND DISCLOSURE: 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, the Contractor shall contact the Department as soon as practical. Contractor must submit any proposed media release regarding the terms of this Contract to the Department for review and approval at least seven (7) State Business Days in advance of intended disclosure, to the extent practicable. The Department may, to the extent reasonable and lawful, timely 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 or by any court of competent jurisdiction to disclose.

c. *Section III. B. General Terms and Conditions,* ***30. MONITORING OF SUBCONTRACTORS:*** is revised and restated as follows:

30. MONITORING OF SUBCONTRACTORS: Contractor shall perform on-going monitoring of all Subcontractors and shall confirm compliance with subcontract requirements. As part of on-going monitoring, the Contractor shall identify to the Subcontractor(s) deficiencies or areas for improvement and shall require the Subcontractor(s) to take appropriate corrective action. Contractor shall perform a formal performance review of all Subcontractors at least annually.

d. *Section III. B. General Terms and Conditions,* ***45. TERMINATION:****, b.-c.* is revised and restated as follows:

b. Termination without Cause:
This Contract may be terminated, in whole or in part, without cause by the Department by giving at least one hundred and eighty (180) Calendar Days' prior written notice to the other Party. The termination shall be effective at 11:59:59 p.m. on the last day of the calendar month in which the one hundred and eighty (180) Calendar Days' notice period expires. In the event of termination without cause:
   i. Department and Contractor shall work together daily in good faith to minimize any disruption of services to NC Medicaid Beneficiaries;
   ii. Contractor shall perform all the Contractor transition and other obligations specified in the Contract;
   iii. Department and Contractor shall resolve any outstanding obligations under this Contract; and
   iv. Contractor shall pay Department in full any refunds or other sums due to Department under this Contract.

c. Termination for Cause:
   i. In accordance with 42 C.F.R. § 438.708, Department shall have the right to terminate this Contract with Contractor and to enroll Contractor's members in other managed care plans if Department determines that Contractor has materially breached (and subsequently failed to cure) this Contract or has failed to meet applicable requirements in Sections 1905(t), 1903(m), and/or 1932 of the Social Security Act.
   ii. Upon written notification to Contractor of Department's intent to terminate this Contract, the Department may give Members written notice of such intent and allow the members to disenroll immediately without cause in accordance with 42 C.F.R. § 438.722.
   iii. If the Department seeks to terminate this Contract pursuant to 42 C.F.R. § 438.708, the Department shall provide Contractor with a pre-termination hearing as required by 42 C.F.R. § 438.710(b) and as described in this Contract.
   iv. Department shall have the right to terminate this Contract for cause when the performance of Contractor or one of its Subcontractors has systemically or repeatedly threatened to place the health or safety of any Beneficiary in jeopardy, and Contractor knew or should have known of the issue and failed to take appropriate action immediately to correct the problem;
   v. Department shall have the right to terminate this Contract for cause when Contractor becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p);
   vi. Department shall have the right to terminate this Contract for cause when Contractor has systemically and fraudulently misled any Beneficiary or has systemically and fraudulently misrepresented the facts or law to any Beneficiary, and Contractor failed to take appropriate action immediately to correct the problem;

vii. Department shall have the right to terminate this Contract for cause when gratuities of any kind with the intent to influence have been offered or received by a public official, employee, or agent of the State by or from Contractor, its agents or employees;

viii. Department shall have the right to terminate this Contract for cause if Contractor loses or fails to obtain accreditation with the selected accreditation agency.

ix. Department shall have the right to terminate this Contract for cause if Contractor declares bankruptcy.

x. Department shall have the right to terminate this Contract as otherwise set forth in this Contract.

e. *Section III. B. General Terms and Conditions,* ***48. <u>USE OF THIRD PARTY ADMINISTRATOR:</u>*** is revised and restated as follows:

48. <u>USE OF THIRD PARTY ADMINISTRATOR:</u> If Contractor uses the services of a Third Party Administrator (TPA) to adjust or settle claims for members, then the Contractor shall do all of the following contingent upon a change in state-law to require the BH I/DD Tailored Plan be licensed as a Prepaid Health Plan (PHP) set forth by the North Carolina Department of Insurance (DOI), as outlined in Article 93 of Chapter 58 of the N.C. General Statutes:

a. Ensure the TPA has a current license issued by, and is in good standing with DOI, as required by N.C. Gen. Stat. §§ 58-56-2(5) and 58-56-51;

b. Have a written agreement with the TPA that is compliant with Article 56 of Chapter 58 of the General Statutes, as applicable, and includes a statement of the duties the TPA is expected to perform on behalf of the Contractor, as specified in N.C. Gen. Stat. § 58-56-6;

c. Establish the rules, in accordance with this Contract, pertaining to claims payment and shall provide the TPA with the rules in accordance with N.C. Gen. Stat. § 58-56-26 ; and

d. Submit to the Department an attestation that the Contractor understands it is solely responsible to provide for competent administration of its claims under the Contract, as provided in N.C. Gen. Stat. § 58-56-26.

e. Notwithstanding the contingency statement above, the Contractor shall do all of the following until such time that state law requires the BH I/DD Tailored Plan to be licensed as a Prepaid Health Plan (PHP) as set forth by the North Carolina Department of insurance:

i. Have a written agreement with the TPA that at a minimum includes a statement of the duties the TPA is expected to perform on behalf of the Contractor; and

ii. Include specific provisions in Contractor's written agreement with the TPA outlining Contractor's requirements for claims payment, in accordance with the requirements of this Contract.

f. *Section III. B. General Terms and Conditions* is revised to add the following:

50. <u>SUBSTANCE USE DATA (42 CFR PART 2):</u> Contractor is fully bound by the provisions of 42 CFR Part 2 upon receipt of data from DHB that includes Patient Identifying Information (PII) regarding substance use disorder, as those terms are defined by 42 CFR 2.11. Contractor shall implement appropriate safeguards to prevent the unauthorized uses and disclosures of data protected under 42 CFR Part 2. Contractor shall report any unauthorized uses, disclosures, or breaches of data subject to this term and condition, to the Contract Administrators for DHB within three (3) Business Days of the unauthorized use, disclosure, or breach. This notice is in addition to any other notice requirement regarding unauthorized disclosure of PII or PHI required by the Contract. Information disclosed to Contractor is limited to that which is necessary for the Contractor to perform its duties under the Contract. Contractor shall not re-disclose information to a third party unless that third party is a contract agent of the Contractor or subcontractor, helping to provide services described in the contract and only if the subcontractor only further discloses the information back to the contractor or lawful holder from which the information originated.

g. *Section III. C. Confidentiality, Privacy and Security Protections, 2. Confidential Information, a.-b.* is revised and restated as follows:

a. The Contractor, its agents, and its Subcontractors shall maintain the privacy, security and confidentiality of all data information, working papers, and other documents related to the performance of the Contract, including information obtained through its performance under the Contract, that meets the conditions for confidentiality under NCGS 132-1.2, is otherwise protected by law or applicable policy as confidential, or is identified by the Department as confidential, or not for release; i.e. confidential information. Any use, sale, or offer of confidential information associated with the performance of the Contract except as contemplated under the Contract or approved in writing by the Department shall be a violation of the Contract. Any such violation will be considered a material breach of the Contract. Contractor specifically warrants that it, its officers, directors, principals, employees, any Subcontractors, and approved third-party contractors shall hold confidential information received from the Department during performance of the Contract in the strictest confidence and shall not disclose the same to any third party except as contemplated under the Contract or approved in writing by the Department.

b. Contractor warrants that all its employees Subcontractors, and any approved third-party Contractors are subject to a non-disclosure and/or confidentiality agreement or provisions that is/are enforceable in North Carolina and sufficient in breadth to include and protect confidential information related to the Contract. The Contractor shall, upon request by the Department, verify and produce true copies of any such agreements/provisions. Production of such agreements by the Contractor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Contractor produces satisfactory evidence supporting exclusion of such agreements from disclosure under the North Carolina Public Records laws in N.C. Gen. Stat. § 132-1 et. Seq. The Department may provide a lawful, reasonable non-disclosure and confidentiality agreement for the Contractor's execution. The Department may exercise its rights under this paragraph as necessary or proper, in its discretion, to comply with applicable security regulations or statutes, including but not limited to 26 U.S.C. 6103, SSA, and IRS Publication 1075 (Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities), HIPAA, and implementing regulation in the Code of Federal Regulations and any future regulations imposed upon the Department of Information Technology Services or the North Carolina Department of Revenue pursuant to future statutory or regulatory requirements.

h. *Section III. C. Confidentiality, Privacy and Security Protections, 10. Privacy and Security Incidents and Breaches, b.* is revised and restated as follows:

b. Contractor shall report privacy and significant cybersecurity incidents as defined by N.C.G.S. § 143B-1320(a)(16a) (whether confirmed or suspected) to the Department's PSO Incident Website at the following link, accurate as February 6, 2023: https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security within twenty-four (24) hours after the incident is first discovered. If a Social Security number has been compromised, the incident must be reported to the Department's PSO within sixty (60) minutes after the incident is discovered.

i. *Section III. E. Dispute Resolution for Contract Compliance, 5.* is revised and restated as follows:

5. If the unresolved dispute appears to impact more than one PIHP, the Department Contract Administrator shall notify Department leadership, who will develop a plan of action with multiple PIHPs for resolving the dispute. The goal of the resolution process shall be to resolve all problems before they escalate to the next level. The Department and PIHP Contract Administrators shall schedule telephone or face to face meetings as necessary in order to achieve resolution without conflict where possible.

3. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

a. *Section IV. Scope of Services, A. Administration and Management, 1. Medicaid Program Administration, a.-e.* is revised and restated as follows:

a. In the State of North Carolina, the Department 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 (DHB) is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) program~~s~~. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the Medicaid program. In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid program through its Regional Office in Atlanta, Georgia and its Center for Medicaid, Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.

b. The Department has the authority to determine North Carolina Medicaid eligibility and define the populations excluded or delayed from managed care who are thereby eligible to receive Behavioral Health and I/DD Services for Medicaid Direct through the PIHP consistent with G.S. 108D-60 as amended from time to time.

c. The Department has the authority to administer the program in the way outlined in this Contract under the terms of the State's waivers under Section 1915(i) and 1915(c), of the Social Security Act and various Medicaid State Plan Amendments.

d. During the term of the Contract, and in future years, the Department will modify its Medicaid Program, including supporting technical and operational infrastructure, to conform with Federal and State requirements or Department policies and goals. Modifications may be communicated through State Plan Amendments, Waiver amendments, and administrative memos and bulletins issued by the Department. The PIHP is obligated to review such memos and bulletins to assist in staying informed of program changes.

e. The Department will remain responsible for all aspects of the North Carolina Medicaid program and will delegate the direct management of BH and I/DD services as defined in the Contract (Behavioral Health and I/DD Services for Medicaid Direct). Nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Department to perform any of the duties assigned to the Department or its Secretary by the North Carolina General Statutes, the terms and conditions of the federal funds and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by the PIHP to reimburse the PIHP for any of its duties under this Contract. The PIHP will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the PIHP has an adequate Network, delivers high quality care, and operates a successful program.

b. *Section IV. Scope of Services, A. Administration and Management, 1. Medicaid Program Administration, j.* is revised and restated as follows:

j. The PIHP shall also comply with the following Department policies and any other Department policy as directed consistent with this Contract. The Department may amend policies and shall provide updated versions to the PIHP at least sixty (60) Calendar Days prior to its intended effective date or the date defined by the Department. The PIHP shall have the opportunity to review and provide feedback for the Department's consideration prior to the effective date of such policy revisions.

i. North Carolina Medicaid Direct for BH and I/DD Services Enrollment Policy;

ii. AMH+ Practice and CMA Certification Policy;

iii. Uniform Credentialing and Re-credentialing Policy;

iv. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards;
v. Tribal Payment Policy;
vi. Transition of Care Policy;
vii. PIHP Member Advisory Committee Guidance;
viii. Managed Care Clinical Supplemental Guidance; and
ix. Notice of Adverse Benefit Determination Clearinghouse Upload Instructions.

c. *Section IV. Scope of Services, A. Administration and Management, 1. Medicaid Program Administration, l.* is revised and restated as follows:

l. To support Medicaid Direct PIHP implementation and operations, the PIHP shall perform the following testing and technology operations:
   i. Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable;
   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; and
   iii. Production defect resolution and testing of production incidents.

d. *Section IV. Scope of Services, A. Administration and Management, 6. Staffing and Facilities, g. iv.* is revised and restated as follows:

iv. For Key Personnel positions that require the employee to reside in North Carolina, the PIHP shall adhere to North Carolina Residency Requirements as defined in *Section II. A. Definitions, 149. North Carolina Residency*.

e. *Section IV. Scope of Services, A. Administration and Management, Section IV. A.6.: Table 1. Key Personnel Requirements for the PIHP* is revised and restated as follows:

Section IV.A.6: First Revised and Restated Table 1. Key Personnel Requirements for the PIHP				
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**	**Position May be Shared Across PIHP and BH I/DD Tailored Plan**
1.	Chief Executive Officer (CEO) of North Carolina Medicaid	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	• Must meet North Carolina residency requirements under this Contract • Must hold a Master's degree from an accredited college or university	Yes
2.	Chief Financial Officer (CFO) of North Carolina Medicaid	Individual responsible for accounting and finance operations, including financial audit activities	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution • Minimum of seven (7) years of progressive accounting experience, of which three (3) years are supervisory	Yes

Section IV.A.6: First Revised and Restated Table 1. Key Personnel Requirements for the PIHP				
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**	**Position May be Shared Across PIHP and BH I/DD Tailored Plan**
3.	Chief Operating Officer (COO) of North Carolina Medicaid	Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree from an accredited college or university • Minimum of seven (7) years of experience in a managed care organization	Yes
4.	Chief Medical Officer or Deputy CMO for the PIHP	Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, population health and care management, and quality management.	• Must meet North Carolina residency requirements under this Contract • Must be a psychiatrist, fully licensed to practice in NC and in good standing. • Minimum of five (5) years of experience in a health clinical setting and five (5) years' experience in managed care • Clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience)	May be the same staff member identified as the CMO or Deputy CMO of the BH I/DD Tailored Plan, if that staff member is a psychiatrist fully licensed to practice in NC
5.	Chief Compliance Officer	Individual who oversees and manages all fraud, waste, and abuse and compliance activities	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree from an accredited college or university	Yes
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO)	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree in information security or computer science from an accredited college or university • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years of experience in health care	Yes
7.	Quality Director	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving,	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO)	Yes, however, individual should report to the Chief Medical Officer for the PIHP for responsibilities within the

Section IV.A.6: First Revised and Restated Table 1. Key Personnel Requirements for the PIHP				
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**	**Position May be Shared Across PIHP and BH I/DD Tailored Plan**
		tracking and trending quality of care grievances.	• Certified Professional in Healthcare Quality (CPHQ) is preferred	scope of this Contract
8.	Utilization Management Director	Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and the peer review functions of related member appeals.	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated utilization review and management experience in behavioral health and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT)	Yes; however, individual should report to the Chief Medical Officer for the PIHP for responsibilities within the scope of this Contract
9.	Provider Network Director	Individual responsible for provider services and provider relations, including all network development and management issues. Individual reports to the COO.	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of combined network operations, provider relations, and management experience	Yes
10.	Director of Population Health and Care Management	Individual responsible for providing oversight and leadership of all prevention/population health, care management and care coordination programs, including oversight of care management provided by AMH+ practices and CMAs	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated care management/population health experience in a healthcare organization serving Medicaid beneficiaries, including experience with BH and I/DD populations • North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT)	Yes
11.	I/DD and TBI Clinical Director	Individual who oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid and Innovations and TBI waiver services to members , developing clinical practice standards, clinical policies and procedures, utilization management, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with BH benefits.	• Must meet North Carolina residency requirements under this Contract • Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI • Minimum of seven (7) years of utilization review, care management, and/or habilitative and case management experience in I/DD care	Yes

f. *Section IV. Scope of Services, A. Administration and Management, 6. Staffing and Facilities, q. Conflict of Interest, ii.* is revised and restated as follows:

ii. The PIHP shall undertake reasonable actions to verify that employees or Subcontractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, State, or county money under the North Carolina Medicaid program, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.

g. *Section IV. Scope of Services, A. Administration and Management,* is revised to add the following:

8. COVID-19 Public Health Emergency Response and Unwinding
   i. During the ongoing response to the Coronavirus-19 (COVID-19) pandemic, it is critical that the Department work with Contractor to institute efforts to keep Members healthy by taking steps to protect Members from infectious disease, providing access to testing, treatment and vaccine administration for COVID-19, ensuring care for ongoing chronic or acute conditions, and supporting Members and providers through the COVID-19 Public Health Emergency Unwinding.
   ii. The PIHP shall comply with all Department COVID-19 Policy Flexibilities, including modifications to NC Medicaid Clinical Coverage Policies and other modifications under State authority, and modifications under Federal authority as approved by the Centers for Medicare and Medicaid Services (CMS) and implemented by the Department and as communicated through applicable Special COVID-19 Bulletins and Letters to Managed Care CEOs issued by the Department.
   iii. The PIHP shall be responsible for ensuring that all guidance, trainings and technical assistance it provides to Members and providers are consistent with Federal and/or State guidance.
   iv. The PIHP shall comply with *Section VI. Attachment L.6. COVID-19 Public Health Emergency Managed Care Policy.*

h. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, l.* is revised and restated as follows:

l. The PIHP shall ensure the service lines are staffed with professionals who have sufficient training and knowledge, as defined in *Section IV.B.3. Staff Training, on North Carolina Medicaid* as defined within this Contract.

i. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, n., ii., 1.* is revised and restated as follows:

1. Member resources, education and assistance to understand Medicaid benefits and benefits available through the PIHP and physical health services in NC Medicaid Direct;

j. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, o., ii.* is revised and restated as follows:

ii. Medicaid identification number (preferred);

k. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, r. Behavioral Health Crisis Line* is revised and restated as follows:

r. Behavioral Health Crisis Line:
   i. Must be staffed with licensed BH professionals.
   ii. Must be able to address mental health, SUD, and I/DD-related crisis events.
   iii. Must immediately connect to the crisis response systems.
   iv. Must have patch capabilities to 911 emergency services. In instances where there is immediate danger to self or others, the PIHP 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.

v. Must follow up with the Member's care manager, as relevant, to share relevant clinical and follow up information.

vi. The PIHP Behavioral Health Crisis Line may use Interpretation services for no more than twenty percent (20%) of Behavioral Health Crisis Line calls received from members who prefer to speak in Spanish, but these interpreters must be Healthcare or Medically Certified.

1. Interpreters must have at least one of the following certifications:
    a. Certified Medical Interpreter from NBCMI;
    b. Certified Healthcare Interpreter from CCHI;
    c. Core Certification Healthcare Interpreter from CCHI; or
    d. Internal Medical/Healthcare Medical Certification from Language/Interpreter Vendor.
2. When providing services to Members, Behavioral Health Crisis Line bi-lingual agents may be located outside of North Carolina.

vii. Must not:

1. Allow Members to receive a busy signal;
2. Allow Member calls to be answered by an automated response;
3. Allow Members to leave messages and receive a call back;
4. Shift calls to an overflow system during high volume call times; or
5. Allow maximum call duration limits.

l. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, s. v.* is revised and restated as follows:

v. The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers, if applicable. The PIHP is required to submit a request to the Department for review and approval for a call center used by the PIHP, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract.

m. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines* is revised to add the following:

t. Gross Customer Abuse

a. The PIHP shall prohibit gross customer abuse by call center agents across its service lines. Gross customer abuse includes any of the following actions performed by a call center agent, as determined by the Department:
    i. Use of profanity or vulgar language;
    ii. Yelling or screaming at callers;
    iii. Intentional disconnection with the caller; and
    iv. Negligent or willful misconduct.

b. As part of its call center quality assurance and monitoring approach, the BH I/DD Tailored Plan shall monitor its service lines for gross customer abuse and report any identified incidents to the Department. Any complaints received by the BH I/DD Tailored Plan from a caller claiming gross customer abuse shall be reported to the Department. The BH I/DD Tailored Plan shall report incidents of gross customer abuse to the Department within two (2) Business Days after the incident is reported to or discovered by the BH I/DD Tailored Plan, in a format and manner defined by the Department.

c. The Department will monitor service lines for gross customer abuse during call center quality assurance procedures such as call report reviews listening observations or investigating external complaints.

n. *Section IV. Scope of Services, C. Compliance, 1. Compliance Program, c., iii.* is revised and restated as follows:

iii. The establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the PIHP's Compliance Program and its compliance with the requirements under the Contract. The Regulatory Compliance Committee may serve as the committee for both the PIHP and the BH I/DD Tailored Plan.

o. *Section IV. Scope of Services, C. Compliance, 2. Program Integrity (PI), c., i. Validation of Exclusion List Status* is revised and restated as follows:

i. Validation of Exclusion List Status
   1. The PIHP shall, prior to contracting, check the exclusion status of all providers against the Exclusion Lists to ensure that the PIHP does not pay state or federal funds to excluded persons or entities.
   2. The PIHP shall disclose to the Department within thirty (30) Calendar Days of the PIHP's knowledge of any disciplinary actions or exclusions that have not been communicated on the Provider Enrollment File as a Termination to the PIHP imposed on any licensed physician, physician assistant, nurse practitioner, psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within the Contract.
   3. The PIHP shall check, at least every month, the exclusion status of persons, agents, or managing employees of a delegated entity or subcontractor against the Exclusion Lists to ensure that the PIHP does not pay federal or state funds to excluded persons or entities. The PIHP shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a).
   4. The PIHP shall take appropriate action upon identification that a person, agent, managing employee, delegated entity or Subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.
   5. The PIHP shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:
      a. The name(s) of the Excluded Person(s);
      b. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
      c. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.

p. *Section IV. Scope of Services, C. Compliance, 3. Fraud, Waste, and Abuse Prevention, c. Investigation Coordination, viii.* is revised and restated as follows:

viii. The PIHP cannot take action, termination of provider, or suspension of payment, or withhold of payment, related to potential findings of fraud without approval of the Department. Any such action taken after PIHP has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.

q. *Section IV. Scope of Services, C. Compliance, 3. Fraud, Waste, and Abuse Prevention, c. Investigation Coordination* is revised to add the following:

xi. Any cases that are being actively investigated by the LME/MCO at the time of PIHP launch shall continue after launch.

r. *Section IV. Scope of Services, C. Compliance, 4. Third-Party Liability (TPL), c. Cost Avoidance, i., 6.* is revised and restated as follows:

6. Member Medicaid ID;

s. *Section IV. Scope of Services, C. Compliance, 4. Third-Party Liability (TPL), j., ii.* is revised and restated as follows:

ii. The PIHP shall load and submit to the Department updates and additions on other forms of insurance into its system within five (5) Business Days of matching and verification and the PIHP is required to review State TPL data prior to denying any claim for TPL or other insurance.

t. *Section IV. Scope of Services, C. Compliance, 4. Third-Party Liability (TPL)* is revised to add the following:

m. The PIHP shall pay and then chase for the following services:

i. Medical Support Enforcement: The PIHP shall pay and chase if the claim is for a service provided to a Member on whose behalf child support enforcement is being carried out if:

1. The third-party coverage is through an absent parent; and
2. The provider certifies that, if the provider has billed a third party, the provider has waited one hundred (100) Calendar Days from the date of service without receiving payment before billing the PIHP.

ii. Preventive Pediatric Services: The PIHP shall pay and chase for claims for preventive pediatric services, including EPSDT.

iii. In addition to medical support enforcement and preventative pediatric services, *Section IV. C. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits* lists programs and services that are an exception to the general rule that NC Medicaid is the payer of last resort. When a Member of the PIHP is entitled to one or more of the following programs or services, then the PIHP shall pay and chase the claim.

Section IV C. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits		
Program or Service	Federal	State
1. Crime Victims Compensation Fund	X	
2. Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
3. Ryan White Program	X	
4. Indian Health Services	X	
5. Veteran's Benefits for state nursing home per diem payments	X	
6. Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility	X	
7. Women, Infants and Children Program	X	
8. Older American Act Programs	X	
9. World Trade Center Health Program	X	
10. Grantees under the Title V of the Social Security Act	X	
11. Division of Service for the Blind		X
12. Division of Public Health "Purchase of Care" Program		X
13. Vocational Rehabilitation Services		X
14. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

u. *Section IV. Scope of Services, C. Compliance, 5. Medicaid Service Recipient Explanation of Medical Benefit (REOMB), c.-e.* is revised and restated as follows:

c. The PIHP shall exclude those claims that include sensitive information and Medicare crossover claims when creating the REOMB. Sensitive information shall be defined as any procedures for allergies, newborn treatment and care, substance use disorder information protected by 42 C.F.R. Part 2, and any

treatment for a Member's reproductive health including but not limited to pregnancy, sterilization, and screening and treatment for communicable diseases.

d. The PIHP shall exclude sensitive information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with N.C. Chapter 48A.

e. The PIHP shall send a REOMB for at least ten percent (10%) of all claims or one hundred sixty-five (165) claims for the month whichever is less. (Excluded claims include those in referenced in this Section).

v. *Section IV. Scope of Services, D. Stakeholder Engagement and Community Partnerships, 4. Development of Housing Opportunities for Members, g. Education and Outreach* is revised to add the following:

v. Improve the capacity and performance of service providers to sustain supportive housing and improve retention rates in accordance with TCL Housing Guidelines issued by the Department.

vi. The PIHP Shall:

1. Accomplish the milestones required under TCL related to supportive housing for individuals participating in TCL. A designated single point of contact (Housing Coordinator) at the PIHP shall be identified to coordinate all housing efforts and work closely with the Department's TCL team members.
2. Meet PIHP-specific housing goals as established annually by the Department on or before July 1 of each State fiscal year. The Department and the PIHP will determine the number of slots the Plan will fill for each year of the Settlement Agreement in accordance with N.C.G.S. § 122C-20.10.
3. Oversee annual Housing Quality Inspections (HQS) to ensure that each permanent supportive housing unit is safe, fully functional, and sanitary.

w. *Section IV. Scope of Services, D. Stakeholder Engagement and Community Partnerships, 5. Community Crisis Services Plan, e.* is revised and restated as follows:

e. Reserved.

x. *Section IV. Scope of Services, D. Stakeholder Engagement and Community Partnerships, 5. Community Crisis Services Plan, f.* is revised and restated as follows:

f. The PIHP shall coordinate with Standard Plans, BH I/DD Tailored Plan, and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BH crisis management as defined in each local area crisis services plan and alternatives to involving law enforcement in behavioral health crisis response.

y. *Section IV. Scope of Services, E. Members, 1. Eligibility and Enrollment for PIHPs, a. Department Roles and Responsibilities, i.* is revised and restated as follows:

i. The Department has authority to determine North Carolina Medicaid eligibility and define the populations excluded or delayed from managed care who are thereby eligible for a PIHP consistent with N.C. General Statute § 108D-60 as amended by S.L. 2021-64, s. 3.4A.

z. *Section IV. Scope of Services, E. Members, 1. Eligibility and Enrollment for PIHPs, b. PIHP Enrollment and Disenrollment, i. PIHP Roles and Responsibilities, 3.-5.* is revised and restated as follows:

3. The PIHP shall have staff with sufficient knowledge about the North Carolina Medicaid program and eligibility categories to process and resolve exceptions related to eligibility and enrollment member information as defined by the Department.
4. The PIHP shall notify the Department in a format defined by the Department within five (5) Business Days after it identifies information in a member's circumstances that may affect the member's Medicaid eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member. 42 C.F.R. § 438.608(a)(3).

5. The PIHP shall ensure automatic reenrollment of a member who is disenrolled solely because they lose North Carolina Medicaid eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g). From September 27, 2022 through seventeen (17) months after the end of the COVID-19 Public Health Emergency, the PIHP shall ensure automatic reenrollment of a Member who is disenrolled solely because he or she loses North Carolina Medicaid eligibility for a period of ninety (90) days as allowed in under the Department's CMS approved waiver of Automatic Reenrollment into Medicaid Managed Care Plans as defined in section 1902(e)(14)(A) of the Social Security Act.

aa. *Section IV. Scope of Services, E. Members, 2. Transitions of Care, b. Crossover Population, vii.* is revised and restated as follows:

vii. The PIHP must honor existing and active medical prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans for the first ninety (90) days after PIHP implementation or until the end of the authorization period, whichever occurs first to ensure continuity of care for Members. For service authorizations managed by an LME/MCO and impacted by 42 C.F.R. Part 2, the PIHP shall deem authorizations submitted directly by impacted providers as covered under this requirement. For the first ninety (90) days after PIHP launch, the PIHP shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network providers equal to that of in network providers until end of episode of care or the ninety (90) days after PIHP launch, whichever is less. The PIHP shall process and pay for services rendered during this Crossover transitional period if:
   1. A provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service, or
   2. A provider submits for retroactive prior authorizations.

bb. *Section IV. Scope of Services, E. Members, 3. Member Engagement, h*. Communications with Members and Potential Members. viii, is revised and restated as follows:

viii. The PIHP shall also include on its Member Portal the ability for Members, at a minimum to:
   1. Request a change to their Tailored Care Management Entity or Provider.
   2. Update their contact Information, including opting into or out of text and/ or email communications.
   3. Check the status of a claim.
   4. Find information about their benefits or coverage category.
   5. Submit grievances.
   6. Request appeals for Medicaid services.

cc. *Section IV. Scope of Services, E. Members, 3. Member Engagement, m. Member Handbook, iii., 19.* is revised and restated as follows:

19. Reserved.

dd. *Section IV. Scope of Services, E. Members, 3. Member Engagement, n. Member Education and Outreach, iii.-iv.* is revised and restated as follows:

iii. Any outreach or education related to the proposed Member Incentive Program (as described in *Section IV.E.2. Transitions of Care*) must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater member engagement will not require approval.

iv. In support of the Department's Health Equity goals, the PIHP shall develop a Member Engagement and Marketing Plan for Historically Marginalized Populations for review by the Department. The plan shall include the PIHP's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. The plan shall be submitted no

later than January 6, 2023, and annually thereafter to the Department. As long as the Member Engagement and Marketing Plan for Historically Marginalized Populations clearly states it applies to the PIHP, it may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract and annually thereafter to the Department.

ee. *Section IV. Scope of Services, E. Members, 3. Member Engagement, p. Engagement with Beneficiaries Utilizing Long Term Services and Supports* is revised to add the following:

ix. The PIHP shall adhere to the Department's PIHP Member Advisory Committee Guidance.
x. The PIHP shall develop a LTSS Member Advisory Committee Charter in accordance with the Department's PIHP Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Charter.
xi. The PIHP shall develop a LTSS Member Advisory Committee Recruitment Plan in accordance with Department's Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Plan.

ff. *Section IV. Scope of Services, E. Members, 5. Member Rights and Responsibilities, i.* is revised and restated as follows:

i. Reserved.

gg. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, d., i.* is revised and restated as follows:

i. The PIHP shall give the Member timely and adequate notice of an Adverse Benefit Determination in writing consistent with the notice content and timing requirements below and in 42 C.F.R. § 438.10. 42 C.F.R. § 438.404(a). The PHP shall give the provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.210(c).

hh. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, ii., 2.* is revised and restated as follows:

2. The reasons for the Adverse Benefit Determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);

ii. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, v. Timing of the Notice of Adverse Benefit Determination* is revised and restated as follows:

v. Timing of the Notice of Adverse Benefit Determination
   1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PIHP shall give written notice to the Member, and when applicable, an authorized representative at least ten (10) Calendar Days before the date of the adverse benefit determination is to take effect, except as provided in this Section. 42 C.F.R. §§ 438.404(c)(1) and 431.211.
   2. For termination, suspension, or reduction of previously authorized Medicaid-covered services the PIHP shall provide written notice as expeditiously as possible and no later than five (5) Calendar Days before the date of the Adverse Benefit Determination if:
      a. The PIHP has facts indicating that action should be taken because of probable fraud by the member; and
      b. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c)(1).

3. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PIHP shall provide written notice no later than by the date of the action when any of the following occurs:
    a. The PIHP has factual information confirming the death of the Member;
    b. The PIHP receives a signed, written statement from the member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
    c. The Member is admitted to an institution where he or she is ineligible under the plan for further services;
    d. The Member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
    e. The PIHP establishes that the Member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
    f. A change in the level of medical care is prescribed by the Member's physician. 42 U.S.C. 1396r(e)(7); 42 C.F.R. §§ 431.213; 438.404(c)(1); 431.231(d).
4. For denial of payment of a Clean Claim, the PIHP shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the Claim. 42 CFR 438.404(c)(2). A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR § 447.45(b) is not an adverse benefit determination.
5. For termination from or denial of participation in the Innovations Waiver program or TBI waiver program, the PIHP shall give written notice to the member, and when applicable, an authorized representative at least ten (10) Calendar Days before the date that the adverse decision is to take effect. Removal from the Registry of Unmet Needs is considered a denial of participation in the Innovations Waiver program or TBI waiver program.
6. For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the PIHP shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).
7. If the member's address is unknown and mail directed to him/her has no forwarding address, the PIHP shall have a contingency plan to provide an Adverse Benefit Determination notification to the member or legally responsible person regarding termination or reduction of previously authorized covered services no later than the date of the benefit determination.

jj. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, xi. Expedited Resolution of Plan Appeals, 4.* is revised and restated as follows:

4. In accordance with N.C.G.S. § 108D-14(a) and 42 C.F.R. § 438.410(a), for expedited appeal requests made by a network provider acting as an authorized representative of the Member on behalf of a Member, the PIHP shall presume an expedited appeal resolution is necessary. The PIHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(b).

kk. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, f. State Fair Hearing Process* is revised and restated as follows:

f. State Fair Hearing Process
    i. PIHP shall comply with Chapter 108D and Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
    ii. The PIHP shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.

iii. The PIHP shall allow Members or their authorized representatives one hundred twenty (120) Calendar Days from the date on the Notice of Resolution issued by the PIHP upholding, in whole or in part, the Adverse Benefit Determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f)(2).

iv. The parties to the State Fair Hearing shall include the PIHP and the Member or, when applicable, the Member's authorized representative. 42 C.F.R. § 438.408(f)(3).

v. The PIHP shall designate a mailing and email address with the OAH for all Fair Hearing communications from OAH and any party to the State Fair Hearing.

vi. The PIHP will designate an email address for receipt of Department communications regarding State Fair Hearings. The PIHP will have a process in place to ensure that Department communications regarding expedited State Fair Hearings requests made pursuant to N.C. Gen. Stat. § 108D-15.1 are responded to as soon as possible and in no event later than nine (9) Work Hours from the timestamp of the Department's email communication. The PIHP will respond to Department communications about standard State Fair Hearing requests per the requirement in *Section III.D.37* ***RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION***. The Department shall notify the PIHP as expeditiously as possible, but no later than nine (9) Work Hours of any expedited State Fair Hearing request involving the PIHP.

vii. The PIHP will have a process in place to upload to the Department all documentation reviewed by the PIHP in connection with the internal plan appeal. For expedited State Fair Hearing requests made pursuant to N.C. Gen. Stat. § 108D-15.1, the PIHP will upload documentation as soon as possible and in no event later than nine (9) Work Hours from the timestamp on the Department communication requesting the documentation. For standard State Fair Hearing requests, the PIHP will upload the requested documentation per the requirements laid out in Section III.D.37 ***RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION.***

viii. Mediation

1. The PIHP shall notify Members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
2. The PIHP shall inform Members that mediation is voluntary and that the member is not required to request a mediation to receive a State Fair Hearing with OAH.
3. The PIHP shall attend and participate in Mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.

ix. Effectuation of Reversed Appeal Resolutions

1. If the PIHP, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PIHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires and no later than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).

2. If the PIHP, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the member received the disputed services while the Appeal was pending, the PIHP shall pay for those services in accordance with the terms of the Contract.

II. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, h.* is revised and restated as follows:

h. Reserved.

mm. *Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals* is revised to add the following:

j. Due Process Principles for Members Obtaining 1915(i) Services: The PIHP shall comply with the following due process principles as they relate to members who are obtaining or seeking to obtain 1915(i) services, including but not limited to development of the member's Care Plan/ISP:

i. If the PIHP authorizes a requested 1915(i) service for a duration less than the duration requested in the Care Plan/ISP, the PIHP shall provide written notice with Appeal rights and clinical or administrative reasons for the decision at the time of the limited authorization.

ii. If the PIHP denies a request for authorization of 1915(i) services by a member, in whole or in part, or authorizes a requested 1915(i) service in a limited manner, including the type, level, or duration of service, the PIHP shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 C.F.R. § 438.404:

1. An Appeal filed by a member must not prevent any authorized 1915(i) services from being provided pending the outcome of the Appeal. The PIHP must not prevent the member from making a new request for 1915(i) services during a pending Appeal.

iii. The PIHP shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all members from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to Appeal the denial, reduction, or termination of a service. The PIHP shall not attempt to influence, limit, or interfere with a member's right or decision to file or pursue a Grievance or request an Appeal.

iv. Care Plan/ISP: The PIHP shall ensure that any request for authorization of 1915(i) services is consistent with and incorporates the desires of the member.

v. The PIHP shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to 1915(i) services and other trainings relevant to due process procedures, whether related to 1915(i) services or otherwise.

nn. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, b., i.* is revised and restated as follows:

i. Cover all BH and I/DD services in the North Carolina Medicaid State Plan;

oo. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, b.* is revised to add the following:

ix. Ensure services available match the needs of individuals receiving ACT, CST, or TMS, including without limitation:

1. Effective implementation of Community Support Team;
2. Evidenced based peer support, focused on individuals in the current and future TCL target population; and
3. Expanding capacity of health providers who are knowledgeable regarding wellness, recovery, and managing and preventing deterioration of chronic health conditions.

pp. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, c. Covered Medicaid Services* is revised and restated as follows:

c. Covered Medicaid Services:

i. Consistent with N.C. Gen. Stat. §§ 108D-60 and 108D-35, the PIHP shall be responsible for covering BH and I/DD services that are defined as *Section IV.F.1. Behavioral Health and I/DD Benefits Package*, as well as any services that the Department obtains authority through a SPA or waiver to cover and adds to the PIHP benefit package.

ii. A crosswalk of the SUD services covered under the Medicaid State Plans to national clinical standards is provided in *Section IV.F.1. Behavioral Health and I/DD Benefits Package*.

iii. The PIHP shall implement changes to covered or carved-out services within thirty (30) Calendar Days after notification by the Department, unless otherwise indicated.

Section IV.F.1. First Revised and Restated Table1: Behavioral Health, I/DD, and TBI Services Covered by PIHP

• Inpatient BH services
• Medically managed intensive inpatient services (Inpatient BH services)
• Medically managed intensive inpatient withdrawal services (Inpatient BH services)
• Outpatient BH emergency room services
• Outpatient BH services provided by direct-enrolled providers
• Psychological services in health departments and school-based health centers sponsored by health departments
• Peer supports
• Partial hospitalization
• Mobile crisis management
• Facility-based crisis services for children and adolescents
• Professional treatment services in facility-based crisis program
• Outpatient opioid treatment
• Ambulatory withdrawal management, without extended on-site monitoring (ambulatory detoxification)
• Ambulatory withdrawal management, with extended on-site monitoring
• Clinically managed residential withdrawal services (social setting detoxification)
• Research-based BH treatment for Autism Spectrum Disorder (ASD)
• Diagnostic assessment
• Medically monitored inpatient withdrawal management (non-hospital medical detoxification)
• Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
• Residential treatment facility services
• Child and adolescent day treatment services
• Intensive in-home services
• Multi-systemic therapy services
• Psychiatric residential treatment facilities (PRTFs)
• Assertive community treatment (ACT)
• Community support team (CST)[1]
• Psychosocial rehabilitation
• Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house)
• Clinically managed population-specific high-intensity residential services
• Clinically managed residential services (Substance abuse non-medical community residential treatment)
• Medically monitored intensive inpatient services (Substance abuse medically monitored residential treatment)
• Substance Use intensive outpatient program (SAIOP)
• Substance Use comprehensive outpatient treatment program (SACOT)
• Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
• Early and periodic screening, diagnostic and treatment (EPSDT) services
• 1915(i) SPA Services:
  ○ Supported employment
  ○ Individual transition and support
  ○ Respite
  ○ Community living and supports
  ○ Community transition

[1] CST includes tenancy supports.

Section IV.F.1. First Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
1	Outpatient services	
2.1	Intensive outpatient services	Substance Use intensive outpatient program
2.5	Partial hospitalization services	Substance Use comprehensive outpatient treatment
3.3	Clinically managed population-specific high-intensity residential services	Clinically managed population-specific high-intensity residential services
3.5	Clinically managed high-intensity residential services	Clinically managed residential services (substance abuse non-medical community residential treatment)
3.7	Medically monitored intensive inpatient services	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)
N/A		Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
4	Medically managed intensive inpatient services	Medically managed intensive inpatient services (Inpatient BH services)
Office-based opioid treatment	Office-based opioid treatment	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment and
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory withdrawal management, without extended on-site monitoring (ambulatory detoxification) Ambulatory withdrawal management, with extended on-site monitoring
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.2-WM	Clinically managed residential withdrawal management	Clinically managed residential withdrawal services (social setting detoxification)
3.7-WM	Medically monitored inpatient withdrawal management	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)
4-WM	Medically managed intensive inpatient withdrawal	Medically managed intensive inpatient withdrawal management (Inpatient BH services)

iv. The PIHP shall provide LTSS in settings that comply with 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. 42 C.F.R. §438.3(o).

v. Changes to Covered Benefits

1. The PIHP shall cover BH and I/DD benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid State Plans and consistent with any approved Medicaid waivers, except to the extent the service is carved out of the PIHP.

vi. Institutions for mental disease (IMD) SUD Services

1. Under North Carolina's 1115 waiver authority, the PIHP shall provide coverage for substance use disorder services for Medicaid Members aged twenty-one (21) through sixty-four (64) in an IMD, as well as any other State Plan services for which they may be eligible during their stay in the IMD.

2. The PIHP shall provide the Department with a weekly report on Medicaid Members who are residing or have resided in an IMD for SUD treatment as defined in Section VI. Attachment I. Reporting Requirements to support 1115 waiver reporting to CMS. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

qq. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, i., 2., k.* is revised and restated as follows:

k. The PIHP shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the PIHP shall submit the attestation required by this Section annually, unless otherwise directed by the Department. The Department will conduct ad hoc reviews of the PIHP's adherence to the attestation of compliance with UM and clinical coverage requirements on an ongoing basis. The PIHP shall provide an analysis of their compliance with the attestation upon request as follows:
   i. Within thirty (30) Business Days for routine requests; and
   ii. Within seven (7) Business Days for expedited requests.

rr. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, Section IV.F.1 Table 6: Required Clinical Coverage Policies* is revised and restated as follows:

Section IV.F.1 First Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	**Scope**
PIHP Services Note: *For these policies, PIHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.*	
Medicaid State Plan BH Services	8A: Enhanced Mental Health and Substance Abuse Services: • Child and Adolescent Day Treatment services • Intensive In-Home Services • Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization • Mobile Crisis Management • Multi-systemic Therapy Services • Partial Hospitalization • Professional Treatment Services in Facility-Based Crisis Program • Psychosocial Rehabilitation (PSR) 8A-1: Assertive Community Treatment 8A-2: Facility-Based Crisis Services for Children and Adolescents 8A-5: Diagnostic Assessment 8A-6: Community Support Team (CST) 8A-7: Ambulatory Withdrawal Management Without Extended On-Site Monitoring (ambulatory detoxification) 8A-8: Ambulatory Withdrawal Management With Extended On-Site Monitoring 8A-9: Opiod Treatment Program 8A-10: Clinically Managed Residential Withdrawal Services (social setting detoxification) 8A-11: Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification) 8A-12: Substance Abuse Intensive Outpatient Program 8A-13: Substance Abuse Comprehensive Outpatient Treatment 8B: Inpatient Behavioral Health Services 8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers

Section IV.F.1 First Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	**Scope**
PIHP Services Note: *For these policies, PIHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.*	
	8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 8D-2: Residential Treatment Services 8D-3: Clinically Managed Low-Intensity residential Treatment Services (substance abuse halfway house) 8D-4: Clinically Managed Population-Specific High Intensity Residential Program 8D-5: Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) 8D-6: Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment)*:* 8F: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder 8G: Peer Supports 8I: Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population
Medicaid State Plan I/DD Services	8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
Medicaid State Plan HCBS	Supported Employment (IDD and MH/SUD) Individual Transition and Supports Community Transition Community Living and Supports Respite
Telehealth (for services within the scope of this contract)	1-H: Telehealth, Virtual Communications and Remote Patient Monitoring

ss. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, xiii., 4., ii. BH Services, i., 2. Mental Health, a.-b.* is revised and restated as follows:

a. Reserved.
b. Reserved.

tt. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management* is revised to add the following:

xvi. The PIHP shall adhere to the Department's Managed Care Clinical Supplemental Guidance, which supplements the NC Medicaid clinical coverage policies.

xvii. UM Policy for 1915(i) Services

1. For 1915(i) services only:
    a. The PIHP shall submit the Department designated 1915(i) assessment tool and necessary information to the Department or the Department's specified vendor for the purposes of completing the independent evaluation to determine eligibly for 1915(i) services in alignment with requirements at 42 C.F.R. § 441.715(d). The PIHP shall comply with any additional guidance released by the Department on the process for supporting the independent evaluation.
    b. The PIHP shall ensure that the independent assessment is used to guide the development of the Care Plan/ISP, and that the results of the independent assessment are not the sole basis for limiting the services requested or approved. The PIHP may use the independent assessment in conjunction with other information to reduce or deny requested services.

2. PIHP shall ensure that any request for authorization of 1915(i) services is consistent with and incorporates the desires of the member and that such desires are reflected in the member's Care Plan/ISP as required by 42 C.F.R. § 441.725(b), including the desired type, amount and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See Section G. 11. Additional Tailored Care Management Requirements for Members Obtaining 1915(i) Services for additional details.
    a. The member's care manager based at a PIHP, AMH+ or CMA shall discuss with the member the duration of the services desired by the member and shall ensure that the Care Plan/ISP requests authorization for each service at the duration requested by the member during the contract year
    b. The member's care manager based at PIHP, AMH+ or CMA shall assist the member in developing a Care Plan/ISP and shall explain options regarding the 1915(i) services available to the member.
3. The PIHP shall inform members that they may make a new request for 1915(i) services at any time by requesting an updated Care Plan/ISP.
4. Care managers based at a PIHP, AMH+ or CMA may not exercise prior authorization authority over the Care Plan/ISP.
5. The PIHP shall issue prior authorizations for all BH, I/DD, and TBI services covered under the 1915(i) SPA according to the requirements set forth in the service definitions that will be established by the Department.
6. The PIHP shall provide any additional information or reports requested by the Department as required by CMS for the 1915(i).
7. Upon the effective date of the 1915(i) SPA, the PIHP shall assess members currently receiving 1915(b)(3) services for transition to the 1915(i) during their birth month (or at the time when 1915(b)(3) services are requested by the member), to support transitioning all members on the 1915(b)(3) to the 1915(i) within one (1) year of the 1915(I) SPA effective date.

uu. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services (ILOS), i.* is revised and restated as follows:

i. The PIHP may use 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)-(iii).

vv. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, j. Cost Sharing, i.* is revised and restated as follows:

i. The PIHP shall not impose cost sharing on Medicaid BH and I/DD services, as defined by the Department.

ww. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, k. Electronic Verification System Requirements, i.* is revised and restated as follows:

i. The PIHP must utilize an Electronic Visit Verification (EVV) system to verify personal care services, the 1915(i) Community Living and Supports services, including all waiver and 1915(i) services that provide assistance with ADLs that are provided in the Member's home and are not provided as a per diem service, prior to releasing payment.

xx. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package* is revised to add the following:

m. If the PIHP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PIHP shall furnish information about the

services it does not cover to the Department, and to any other Department partner as directed by the Department, whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2).

yy. *Section IV. Scope of Services, F. Benefits, 2.* is revised as follows to address a formatting issue. There are no changes to subsections *a.-u.*:

2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members

zz. *Section IV. Scope of Services, G. Care Management and Care Coordination, 1. Overview, c.* is revised and restated as follows:

c. The PIHP will ensure that all Tailored Care Management and Care Coordination are implemented with the goal that people with disabilities have a right under the Rehabilitation Act , Americans with Disabilities Act, and the US Supreme Court decision in Olmstead v LC (1999), to receive community-based services that meet their needs in the most integrated setting possible. In addition, the PIHP shall adhere to the BH I/DD Tailored Plan's Olmstead Plan that aligns with the State Olmstead plan.

aaa. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, a. Model Overview and Objectives, i.-iii.* is revised and restated as follows:

i. The PIHP must ensure that care managers delivering Tailored Care Management coordinate across a Member's whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.
ii. Reserved.
iii. The PIHP should make Tailored Care Management is available to all eligible PIHP Members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative care management services as defined in *Section IV.G.2. Tailored Care Management*.

bbb. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, b. Delivery of Tailored Care Management, i., 2.* is revised and restated as follows:

2. Care Management Agency (CMA): To be eligible to become a CMA, an organization must, at the time of certification, have as its primary purpose the delivery of NC Medicaid or State-funded Services, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina. Provider organizations must be certified as a CMA to provide Tailored Care Management as defined in *Section IV.G.2. Tailored Care Management*.

ccc. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, b. Delivery of Tailored Care Management, ii. Provider-based Tailored Care Management, 3.* is revised and restated as follows:

3. The PIHP shall meet annual requirements established by the Department for the percentage of Members actively engaged in Provider-based Tailored Care Management approaches, meaning Members who are receiving at least one (1) of the following six (6) core Health Home services in that month:
    a. Comprehensive care management; a team-based, person centered approach to effectively manage Members' medical, social and behavioral conditions;
    b. Care coordination: the act of organizing Member care activities and sharing information among all the participants involved with a Member's care to achieve safer and more effective care. Through organized care coordination, Members' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care;

c. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf.
d. Health promotion: education and engagement of a Member in making decisions that promote achievement of good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems;
e. Comprehensive transitional care/follow-up: the process of assisting a Health Home member to transition to a different care setting or through a life stage that results in or requires a modification of services
f. Individual and family supports: the coordinating of information and services to support Health Home members (or their caretakers/guardian) to maintain and promote the quality of life, with particular focus on community living options; or
g. Referral to community and social support services: providing information and assistance for the purpose of referring Health Home members to resources that address their unmet-health resource needs identified in the care plan/ISP.
h. The percentage shall be calculated as:
    i. Numerator: Number of members actively engaged in Tailored Care Management provided by care managers based in AMH+ practices or CMAs certified by the Department; and
    ii. Denominator: Total number of eligible members actively engaged in Tailored Care Management.

ddd. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, b. Delivery of Tailored Care Management, ii. Provider-based Tailored Care Management, 4.* is revised and restated as follows:

4. Each year, the Department will divide the amount of Tailored Care Management that was delivered by AMH+s and CMAs (and Clinically Integrated Networks (CINs) or Other Partners on their behalf) to Members of both the LME/MCO's PIHP and BH I/DD Tailored Plan products by the amount of all Tailored Care Management delivered to Members of the LME/MCO's PIHP and BH I/DD Tailored Plan products. The annual goal percentages for Provider-based Tailored Care Management delivered to the LME/MCO's PIHP and BH I/DD Tailored Plan members are as follows:
    i. Contract Year 1: thirty-five percent (35%);
    ii. Contract Year 2: forty-five percent (45%);
    iii. Contract Year 3: sixty percent (60%); and
    iv. Contract Year 4: eighty percent (80%).

eee. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, c. Eligibility for Tailored Care Management, i.* is revised and restated as follows:

c. Eligibility for Tailored Care Management
    i. All Members who would have otherwise been eligible for a BH I/DD Tailored Plan, as described in S*ection IV.E.1. Eligibility and Enrollment for PIHPs*, if they were not part of a group delayed or excluded from Medicaid Managed Care, as described in *Section IV.E.1. Eligibility and Enrollment for PIHPs*, including those enrolled in North Carolina's 1915(c) Innovations waiver and those using 1915(i) services, are eligible for Tailored Care Management, with the following exceptions for Members participating in services that are duplicative of Tailored Care Management:
        1. Members receiving Assertive Community Treatment (ACT);
        2. Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
        3. Members obtaining care management from the Department's PCCM vendor;

4. Members receiving case management through the CAP/C and CAP/DA programs~~;~~
5. Members participating in the High-Fidelity Wraparound program as described in *Section IV.G.7 Other Care Management Programs*;
6. Members who reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) Calendar Days or longer;
7. Members obtaining Child Assertive Community Treatment (Child ACT);
8. Members obtaining Critical Time Intervention; and
9. Members receiving services through SNFs for more than ninety (90) Calendar Days.

fff. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, d. Enrollment in Tailored Care Management, ii., 4.* is revised and restated as follows:

4. The PIHP shall provide care coordination and manage care transitions for Members who opt-out of Tailored Care Management as described in *Section IV.G.3. Care Coordination and Care Transitions for all Members*.
    a. In cases where a member obtaining 1915(i) services opts out of Tailored Care Management, the PIHP must provide the care coordination services as stipulated by *Section IV.G.12. Additional Care Coordination Functions for Members Obtaining 1915(i) Services*.
    b. In cases where a member enrolled in the Innovations waiver opts out of Tailored Care Management, the PIHP must provide the Innovations waiver care coordination services as stipulated by the Innovations 1915(c) waiver.

ggg. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment* is revised and restated as follows:

f. Tailored Care Management Assignment and Re-Assignment
    i. The PIHP shall ensure that all members have a choice of care management approach (outlined in *Section IV.G.2.b. Delivery of Tailored Care Management*). To facilitate timely engagement in Tailored Care Management, the Department shall make Tailored Care Management assignments as described the Technical Specifications for Tailored Care Management Provider Assignment. The PIHP shall make Tailored Care Management assignments for Medicaid members enrolled in the PIHP after November 30, 2022, using a methodology, consistent with the requirements in this Section, that has been reviewed and approved by the Department.
    ii. The PIHP shall ensure that all eligible Members, including those enrolled in the Innovations waiver, have a choice of organization where they obtain Tailored Care Management.
    iii. The PIHP shall educate Members on the three different care management approaches and provide unbiased counseling on selecting an organization for Tailored Care Management as part of the choice period prior to launch and on an ongoing basis after launch for new members assigned to Tailored Care Management and Members wishing to change the organization where they are obtaining Tailored Care Management.
    iv. A Tailored Care Management Reassignment Policy provides guidance for the assignment of members who have significant changes in their needs and may be better served by a different care management approach (CMA, AMH+ or plan based care management). Member choice must be honored in any reassignment algorithm designed by the PIHP. The PIHP must develop a reassignment policy to be submitted and approved by the Department.
    v. For all Members, the PIHP shall follow the requirements in the Tailored Care Management Auto Assignment Requirements Document, which will be published in the PCDU, as the PIHP develops the PIHP's Tailored Care Management auto assignment algorithm. The PIHP shall assign the Member to a contracted AMH+ practice, CMA, or PIHP within twenty-four (24) hours of effectuation date of enrollment with the PIHP. The Department will share specific deployment schedule for Tailored Care

Management assignment that the PIHP will be required to follow. The algorithm must consider the Member's existing relationships with an AMH+ practice or CMA; the Member's medical, BH, and I/DD complexity; the Member's geographic location; and the capacity at an AMH+ practice or CMA.

vi. The Department will allow PIHPs to submit any proposed changes to the Tailored Care Management Auto Assignment requirements that will be published through the PCDU, for DHHS approval within thirty (30) Calendar Days of Contract Effective Date. Department will review the proposal and provide their response in thirty (30) Calendar Days and align on an implementation plan. If the proposed and approved flexibilities cannot be realistically implemented at launch, then the PIHP will need to implement the functionality per the Department's Tailored Care Management assignment requirements and align on a timeline to implement that post launch.

vii. The PIHP must assign Members to a mix of the three Tailored Care Management approaches (outlined in *Section IV.G.2. Tailored Care Management*) according to the factors described in the Technical Specification for Tailored Care Management Provider Assignment.

viii. The PIHP shall assign members to the most clinically appropriate care management approach as based on the factors described in *Section IV.G.2. Tailored Care Management*, with the exception of most Members in foster care/adoption assistance and former foster youth, must be defaulted to PIHP-based care management. The PIHP must assign each AMH+ and CMA providing Tailored Care Management a justifiably sized population that allows and incentivizes the AMH+ practice or CMA to substantially engage in the model.

ix. The PIHP must ensure that Tailored Care Management assignment aligns with the annual requirements for Provider-based Tailored Care Management as described in *Section IV.G.2. Tailored Care Management*.

x. In addition to the factors outlined in the Technical Specifications for Tailored Care Management Provider Assignment, the PIHP shall consider the following factors when assigning each Member to care management at an AMH+ practice or a CMA, or at the PIHP level:

    1. The PIHP must default Members in foster care/adoption assistance and former foster youth to PIHP-based Tailored Care Management, with the exception of Members who transition from a BH I/DD Tailored Plan and were previously assigned to an AMH+ or CMA who must be auto-assigned to the same AMH+/CMA. However, Members in foster care/adoption assistance and former foster youth must also be given the option to select an AMH+ or CMA.
        a. The PIHP shall monitor care management assignment to ensure that AMH+ practices and CMAs do not select members of their panel based on acuity tier.
    2. BH I/DD Tailored Plan RN/OT teams are responsible for ensuring that the medical and functional needs of its TCL Members are identified and addressed. Duties include:
        a. Conducting medical and functional assessments for Members who have complex needs prior to the transition from a facility to the community. The assessment must include a review of the medical records.
        b. Developing a plan of care based on the medical and functional assessments, discussions with current staff and medical provider(s), and on the Member's goals and choices.
        c. Seeking an FL2 from the medical provider for any physical health or personal care services that the Member will need to improve health status once in the community.
        d. Evaluating the housing unit selected by the member to ensure that it meets the functional needs identified in the assessment.
        e. Ordering any adaptive equipment, durable medical equipment, assistive technology, or medical supplies that the Member will need once in housing.
        f. Observing the Member during medication administration to determine the training needs, technology reminders, and level of confidence that the Member has to administer their own medication and what level of support that they will need.

g. Connecting the Member with primary care and/or specialty care as needed and in close proximity to the area the person chooses to live, as much as can be reasonably accomplished and/or ensuring that transportation is identified and made available to the member for Doctor's visits.
h. Training behavioral health providers on the plan of care.
i. Visiting the home on the first full day that the Member is in the home to ensure that all medical, adaptive, and assistive devices and supplies are in place. Vital signs should be taken at the home, when needed.
j. Working with Tailored Care Managers to understand and to monitor the medical and functional needs of the person and for ensuring that the requirements found in the plan of care are carried out. The RN/OT teams must continue engagement for the first 90 days that the Member is in the community.

xi. The PIHP shall permit Members to change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause.

xii. The Department shall consider the following as appropriate cause for changes in care management approach, assigned organization providing Tailored Care Management, and care manager:
1. The AMH+, CMA, PIHP or care manager has, as determined by the Member or the PIHP, failed to furnish accessible and appropriate services to which the Member is entitled.
2. The AMH+, CMA, PIHP or care manager is not able to reasonably accommodate the Member's needs.
3. There is a change in the accessibility of the AMH+, CMA, PIHP or care manager, including but not limited to the following:
a. The organization or care manager moves to a location that is not convenient for the Member.
b. There is a change in the hours the AMH+ practice or CMA is open, and the member cannot reasonably meet during the new hours.
c. There is a change in the hours the care manager is available, and the member cannot reasonably meet during the new hours.
4. The Member determines that a change would be in the best interest of the Member.
5. The Member's assigned AMH+ practice or CMA leaves the PIHP's Network or is no longer certified by the Department.
6. The Member's assigned AMH+ practice or CMA becomes excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. 438.808(a); 42 C.F.R. 438.808(b)(2); 42 C.F.R. 438.610(b); 42 C.F.R. 431.55(h); section 1903(i)(2) of the SSA; 42 C.F.R. 1001.1901(c); 42 C.F.R. 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09.
7. The care manager is no longer employed by the AMH+, CMA, or PIHP.

xiii. As part of the choice period prior to launch, for new members assigned to the Tailored Care Management, and on an ongoing basis after the launch, the PIHP shall educate members on the three different care management approaches and provide unbiased counseling on selecting an organization for Tailored Care Management.

xiv. At least thirty (30) Calendar Days prior to PIHP launch, the PIHP shall send Members a Tailored Care Management enrollment packet, with information about their Tailored Care Management assignment and options for changing their assignment as part of the Member Welcome Packet.

xv. After the initial launch of the PIHP, on an ongoing basis the PIHP shall complete Tailored Care Management assignment and information to new Members as part of the Member Welcome Packet within eight (8) Calendar Days of the member's enrollment in the PIHP. In the event an existing member is re-assigned to a new Tailored Care Management Entity, the PIHP shall send a notice containing at least the member's new assignment information.

xvi. As part of the Member Welcome Packet sent to members within eight (8) Calendar Days following receipt of the 834 enrollment file (*Section IV.E.3. Member Engagement*), the PIHP must include the following information on Tailored Care Management and care coordination:
    1. Information on the Tailored Care Management program, including services available for those who have opted out of Tailored Care Management;
    2. Information on the PIHP's care coordination program, including services available for members with a BH transitional care need;
    3. The nature of the care manager relationship;
    4. Information on the choice period for Tailored Care Management assignment;
    5. Process and options for changing their Tailored Care Management assignment;
    6. The Tailored Care Management Opt-out form;
    7. Circumstances under which Member information will be disclosed to third parties; and
    8. The availability of the Grievance and Appeals process as described in *Section IV.E.6. Member Grievances and Appeals*.

xvii. The PIHP must share each member's assignment to the organization providing Tailored Care Management with the member's PCP within fourteen (14) Calendar Days of assignment. Upon changes in the Member's assigned PCP, the PIHP must share the Member's Tailored Care Management organization assignment with the Member's new PCP within fourteen (14) Calendar Days of assignment to the new PCP.

xviii. The PIHP must share and receive with each AMH+ and CMA all applicable data files elements specified in *Section IV.G.2. Tailored Care Management.*

xix. The PIHP must assign and must ensure that AMH+ practices and CMAs assign the Member to a care manager with appropriate qualifications and experience according to the Member's needs within thirty (30) Calendar Days of PIHP enrollment.

xx. The PIHP shall submit its policies and procedures for Tailored Care Management assignment as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).

hhh. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, g. Outreach and Engagement for Members Enrolled in Tailored Care Management* is revised to add the following:

v. Beginning July 2024, the PIHP shall provide an annual notice to members who do not engage in Tailored Care Management describing the program and the process for selecting an organization providing Tailored Care Management.

iii. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management, vi.-vii.* is revised and restated as follows:

vi. The assigned organization providing Tailored Care Management shall make its best effort to complete the care management comprehensive assessment within the following timeframes:
    1. Members identified as high acuity: Best efforts to complete it within forty-five (45) Calendar Days of assignment to Tailored Care Management and no longer than sixty (60) Calendar Days after assignment to Tailored Care Management.
    2. Members identified as medium/low acuity: Within ninety (90) Calendar Days of assignment to Tailored Care Management.
    3. For purposes of provisions related to Tailored Care Management, "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the Member's home or working with a known provider to meet the Member at an appointment, to contact the Member if the first attempt is unsuccessful.

vii. During Contract Years after Contract Year 1, the PIHP shall ensure that care managers make best efforts to complete the care management comprehensive assessment for new Members within ninety (90) Calendar Days of assignment to Tailored Care Management.

jjj. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management, x., 3.* is revised and restated as follows:

3. After Significant Changes in scores on Department-approved level-of-care determination and screening tools (e.g., Adult Needs add Strengths Assessment (ANSA), ASAM, Child and Adolescents Needs and Strengths (CANS), and SIS®);

kkk. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management, x., 5., ix.* is revised and restated as follows:

ix. Change in scores on Department-approved level-of-care determination and screening tools (e.g., ASAM, Child and Adolescents Needs and Strengths (CANS), Adult Needs and Strengths Assessment (ANSA), SIS®, and Rancho Los Amigos Levels of Cognitive Functioning Scale).

lll. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management, xii.* is revised and restated as follows:

xii. In circumstances in which a care management comprehensive assessment may have been recently performed in the past six (6) months for MHSA IDD members (excluding innovations) or twelve (12) months for innovations or TBI members, reassessment may consist of an addendum or update to a previous care management comprehensive assessment.

mmm. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management, xv., 7.* is revised and restated as follows:

7. Physical, intellectual, and/or developmental disabilities;

nnn. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management* is revised to add the following:

xxiii. The PIHP shall ensure that, as part of completing the care management comprehensive assessment, the assigned care manager at the organization providing Tailored Care management ask for the member's consent for participating in Tailored Care Management.
    1. As part of the consent process, the care manager must explain the Tailored Care Management program.
    2. Care managers should document in the care management data system that the member provided consent, including the date of consent in addition to any 'wet' or electronic signatures required on the ISP for members on the Innovations and TBI waivers.

ooo. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, j. Development of Care Plan/Individual Support Plan (ISP) for Members Engaged in Tailored Care Management, i.* is revised and restated as follows:

i. Using the results of the care management comprehensive assessment, the assigned organization providing Tailored Care Management shall develop a Care Plan/ ISP. 42 C.F.R. § 441.725.

ppp. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, j. Development of Care Plan/Individual Support Plan (ISP) for Members Engaged in Tailored Care Management, v.* is revised and restated as follows:

v. The PIHP shall ensure the assigned care manager makes Best Efforts to complete an Initial Care Plan or ISP within thirty (30) Calendar Days of the completion of the care management comprehensive assessment. For purposes of completing an Initial Care Plan, "Best Effort" is defined as including at least three documented strategic follow-up attempts, such as going to the Member's home or working with a known Provider to meet the Member at an appointment, to contact the Member if the first attempt is unsuccessful.

qqq. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, j. Development of Care Plan/Individual Support Plan (ISP) for Members Engaged in Tailored Care Management, viii.* is revised and restated as follows:

viii. The PIHP shall ensure that each Care Plan/ISP incorporates results of the care management comprehensive assessment (including Unmet Health-Related Resource Needs questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:

1. Reserved.
2. CANS;
3. ANSA;
4. ASAM criteria;
5. For Innovations waiver enrollees: SIS®; and
6. For members obtaining or seeking to obtain 1915(i) services: independent assessment.

rrr. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, j. Development of Care Plan/Individual Support Plan (ISP) for Members Engaged in Tailored Care Management, x.* is revised and restated as follows:

x. For members with SED, I/DD, or TBI, the Care Plan/ ISP should also include caregiver supports, including connection to respite services, as necessary.

sss. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, j. Development of Care Plan/Individual Support Plan (ISP) for Members Engaged in Tailored Care Management, xv.* is revised and restated as follows:

xv. For specific requirements related to Care Plan/ISPs for Innovations waiver enrollees, see *Section IV.M. Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver*.

ttt. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, k. Care Team Formation for Members Engaged in Tailored Care Management, ii.* is revised and restated as follows:

ii. The PIHP shall ensure that the multidisciplinary care team consists of the following participants as applicable depending on member needs:

1. The Member;
2. Caregiver(s)/legal guardians/foster parents/biological parents/adoptive parents/kinship caregivers (as applicable or appropriate);
3. The member's care manager;
4. Supervising care manager;

5. Care Manager Extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition);
6. PCP;
7. BH provider(s);
8. I/DD and/or TBI providers;
9. Other specialists;
10. Nutritionists;
11. Pharmacists and pharmacy techs;
12. The Member's obstetrician/gynecologist;
13. Peer support specialist;
14. In-reach and/or transition staff;
15. County Child Welfare Worker and guardian ad litem (for members in foster care/adoption assistance); and
16. Other Providers, as determined by the care manager and Member.

uuu. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, l. Ongoing Care Management for Members Engaged in Tailored Care Management, xiii.* is revised and restated as follows:

xiii. The PIHP must ensure that care managers at the assigned organization providing Tailored Care Management meet the minimum contact requirements for Members according to their acuity tier as outlined below unless the Member expresses preference for fewer contacts and this preference is documented in the Care Plan/ISP and reviewed with the supervising care manager or if the member is enrolled in the Innovations waiver (as described in *Section IV.M. Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver*). Contacts may be delivered by the care manager, or care manager extenders, or staff supervised by the care manager, including but not limited to peer support specialists; provided however, that only contacts delivered by the care manager or care manager extender shall count toward contract requirements. In-person contact requirements must be met as described below. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing. If the care manager utilizes two-way real time video and audio conferencing, the care manager shall enable applicable encryption and privacy modes and provide notice to the Member that the third-party application potentially introduces privacy risks. Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used. The administration of the care management comprehensive assessment may count as one of the contacts. The Department intends to release additional guidance on circumstances in which a Member's acuity tier may change.

1. Care manager contacts for Members with BH needs
    i. High Acuity: At least four (4) care manager-to-member contacts per month, including at least one (1) in-person contact with the member.
    ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
    iii. Low Acuity: At least two (2) care manager-to-member contacts per month and at least two (2) in-person contacts member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).
2. Care manager contacts for Members with an I/DD or TBI
    i. High Acuity: At least three (3) care manager-to-member contacts per month, including at least two (2) in-person contacts.

ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
iii. Low Acuity: At least one (1) telephonic or two-way real time video and audio conferencing, contact per month and at least two (2) in-person care manager-to-member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).

3. If the Member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate.
4. For Members who have a guardian, telephonic or two-way real time video and audio conferencing contact may be with a Legally Responsible Person in lieu of the Member, where appropriate or necessary. In-person contacts must involve the Member.
5. In the event that a care manager or care manager extender delivers multiple contacts to a member in one day, only one contact will count towards meeting the contact requirements.

vvv. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, l. Ongoing Care Management for Members Engaged in Tailored Care Management* is revised to add the following:

xvi. Care Management extenders may support care managers in delivering Tailored Care Management by performing activities that fall within the below categories.

1. When an extender performs one of the functions listed below, it may count as a Tailored Care Management contact if phone, video and audio, or in-person contact with the member is made:
   i. Performing general outreach, engagement, and follow-up with members;
   ii. Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
   iii. Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing;
   iv. Sharing information with the care manager and other members of the care team on the member's circumstances;
   v. Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
   vi. Participating in case conferences; or
   vii. Support the care manager in assessing and addressing unmet health-related resource needs.
2. A care manager shall be solely responsible for:
   i. Completing the care management comprehensive assessment;
   ii. Developing the Care Plan/ISP;
   iii. Facilitation of case conferences;
   iv. Ensuring that medication monitoring and reconciliation occur;
   v. Continuous monitoring of progress toward the goals identified in the Care Plan/ISP; and
   vi. Managing care transitions, including creating 90-day transition plans.

www. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, m. Transitional Care Management for Members Engaged in Tailored Care Management* is revised and restated as follows:

m. Transitional Care Management for Members Engaged in Tailored Care Management

i. Regardless of the organization providing Tailored Care Management, the PIHP shall oversee care transitions for all Members engaged in Tailored Care Management who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i) and in addition to the requirements in this Section.

ii. The PIHP shall ensure that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period.

iii. The PIHP shall ensure that TCL eligible members are able to keep their assigned RN and OT care managers.

iv. The PIHP shall ensure that CMAs and AMH+s providing Tailored Care Management carry out the following transitional care management functions.

1. Ensure that a care manager is assigned to manage the transition.
2. Have a care manager assume coordination responsibility for transition planning.
3. Begin discharge planning no later than seven (7) days after the member's admission, including convening a discharge team to assist the individual in developing a plan to achieve outcomes that promote the member's growth, well being and independence, based on the member's strengths, needs, goals and preferences, in the most integrated setting appropriate in all domains of the member's life (including community living, activities, employment, education, recreation, and healthcare).
4. Have a care manager or care team member make best efforts to contact the Member during their stay in an institution (e.g., acute, subacute and long–term stay facilities) and contact them on the day of discharge.
5. For individuals in TCL with RN and OT care management, ensure that RN/OT conduct medical and functional assessments prior to discharge for TCL participants.
6. Conduct outreach to the Member's providers.
7. Ensure development of a written discharge plan through a person-centered planning process in which the member has a primary role and which is based on the principle of self-determination. The discharge plan will be written into the member's Care Plan/ISP and will:
   i. Identify the member's strengths, preferences, needs, and desired outcomes;
   ii. Identify the specific supports and services that build on the member's strengths and preferences to meet the member's needs and achieve desired outcomes;
   iii. Include a pharmacy plan for post-discharge facility medication handling, bridge prescriptions and prescriber, community pharmacy, and those responsible to actively support the individual in obtaining their medications post-transition;
   iv. List providers that can provide the identified supports and services that build on the member's strengths and preferences to meet the member's needs and achieve desired outcomes; and
   v. Set the date of transition as well as the timeframes for completion of all needed steps to affect the transition.
8. Ensure that any barriers preventing the member from being discharged and transitioning into the member's chosen integrated setting are recorded in the member's Care Plan/ISP and, and actively seek solutions for addressing those barriers. Transition barriers shall not include the member's disability or the severity of the disability.
9. Review the discharge plan with the Member and facility staff.
10. Facilitate clinical handoffs.

11. Make best efforts to have all services and supports included in discharge plan will be in place and available to the member on the day of discharge, confirm that the member can be safely discharged without such supports or else, seek to postpone the discharge until such services and supports required for safe discharge, in the sole discretion of the discharge and transition team are in place.
12. Ensure effective implementation of the written discharge plan, including without limitation, the provision of all services and supports at the frequency, duration, intensity, and type agreed upon by the member and the transition team in the member's Care Plan/ISP.
13. For member with a history of re-admission or crises, the factors that led to re-admission or crises and the services, supports, and recovery-oriented interventions shall be identified and addressed in the crisis plan section of the member's Care Plan/ISP.
14. Refer and actively assist Members in accessing and obtaining needed social services and supports identified as part of the transitional care management process, including housing in their written discharge plan.
15. Assist the Member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.
16. Develop a ninety (90) Calendar Day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the Member, facility staff and the Member's care team, that outlines how the Member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.
    i. The ninety (90) Calendar Day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or ISP.
    ii. To the extent feasible, a care management comprehensive assessment should be conducted to inform the ninety (90) Calendar Day post-discharge transition plan.
    iii. The ninety (90) Calendar Day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
    iv. Development of a ninety (90) Calendar Day post-discharge transition plan is not required for all ED visits but may be developed according to the care manager's discretion.
    v. The assigned organization providing Tailored Care Management shall communicate with and provide education to the Member and the Member's caregivers and providers to promote understanding and implementation of the ninety (90) Calendar Day post-discharge transition plan.
17. Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe.
18. Ensure that the assigned care manager follows up with the member within forty-eight (48) hours of discharge.
19. Arrange to visit the member in the new care setting after discharge/transition.
20. Conduct a care management comprehensive assessment within thirty (30) Calendar Days of the discharge/transition or update the current assessment.
21. Update the member's Care Plan/ISP in coordination with the member's care team within ninety (90) Calendar Days of the discharge/transition based on the results of the care management comprehensive assessment.

v. The PIHP must ensure that for individuals with I/DD or TBI, the assigned organization providing Tailored Care Management conducts relevant transitional care management activities in the following "life transitions":

1. Instances where a Member is transitioning out of school-related services;
2. Instances where a Member experiences life changes such as employment, retirement, or other life events; and
3. Instances where a Member has experienced the loss of a primary caregiver or a change of primary caregiver.

vi. The PIHP shall submit its policies and procedures for transitional care management, including the approach to working with members with LTSS needs, as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).

xxx. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, p. Staffing and Training Requirements for Care Managers Delivering Tailored Care Management* is revised and restated as follows:

p. Staffing and Training Requirements for Care Managers Delivering Tailored Care Management

i. The PIHP shall ensure that each care manager is supervised by a supervising care manager. One supervising care manager shall not oversee more than eight (8) care managers.

ii. Supervisors cannot have a caseload but will provide coverage for vacation, sick leave, or unforeseen staffing shortages. They will be responsible for reviewing all Tailored Care Management care plans and Individual Support Plans (ISPs) are complete, reviewing them for quality control, and will provide guidance to care managers on how to meet Members' needs.

iii. The PIHP shall ensure that organizations providing Tailored Care Management (AMH+ practices, CMAs, or the Plan Based have access to clinical consultants in order to access expert support appropriate for the needs of the panel under Tailored Care Management. Clinical consultants are not part of the care team for any given member; rather, the role of clinical consultants is to provide subject matter expert advice to the care team. The AMH+ or CMA may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.

1. While different member needs will require different expertise, the AMH+ or CMA must ensure that it has access to at least the following experts:
   i. A general psychiatrist or child and adolescent psychiatrist;
   ii. A neuropsychologist or psychologist; and
   iii. For CMAs, a primary care physician (PCP) to the extent the beneficiary's PCP is not available for consultation.
2. AMH+ practices and CMAs may demonstrate that they have access to clinical consultants themselves or can contract with other provider organizations to arrange access. The per member per month (PMPM) rate for Tailored Care Management will take these costs into consideration.

iv. Care Management Staff Qualifications

1. The PIHP shall ensure that all care managers, supervising care managers and care manager extenders providing Tailored Care Management meet the following minimum qualification requirements, whether they are employed by the organization itself or employed at the CIN or Other Partner level:
   i. Care managers serving all members must have the following minimum qualifications:
      a. Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104.
      b. For care managers serving members with LTSS needs: two years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. (This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.)

2. The PIHP shall ensure that all supervising care managers overseeing care managers performing Tailored Care Management have the following minimum qualifications:
    i. Supervising care managers serving members with behavioral health conditions must have the following minimum qualifications:
        a. A license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN), and
        b. Three years of experience providing care management, case management, or care coordination to the population being served.
    ii. Supervising care managers serving members with an I/DD or a TBI must have one of the following minimum qualifications:
        a. A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; or
        b. A masters degree in a human service field and three years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; or
        c. A bachelor's degree in a field other than human services and Five years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI.
    iii. If a member is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the PIHP and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the member's care manager.
    iv. The Department will grant a one-time staff exception ('grandfathering') for specified BH I/DD Tailored Plan staff that:
        a. Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan contract award (July 26, 2021).
        b. This exception is based on the staff member possessing the required number of years of experience, but not the required degree, degree type or licensure type.
3. To bolster the care management workforce, the Department will allow BH I/DD Tailored Plans AMH+ practices and CMAs to use care manager extenders, such as community navigators, community health workers, and certified peer support specialists, to support certain Tailored Care Management functions. The purpose of using care manager extenders is to help AMH+ practices, CMAs, and Tailored Plans best meet the needs of members, build efficient care teams by creating additional workforce capacity, and allow care managers and supervisors to focus on key tasks for assigned members as well as permit them additional time for members with intensive or complex needs.
    i. Care manager extenders must have the following qualifications:
        a. At least 18 years of age;
        b. A high school diploma or equivalent; and
        c. Meet one of the following requirements:
            1. Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system; or
            2. Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist; or
            3. A parent or guardian of an individual with an I/DD or a TBI or a behavioral health condition and has at least two years of direct experience providing care for and

navigating the Medicaid delivery system on behalf of that individual (note that a parent/guardian cannot serve as an extender for their family member); or

4. Has two years of paid experience performing the types of functions described in the "Extender Functions" section below, with at least one year of paid experience working directly with the Tailored Care Management eligible population.

ii. The care management functions of extenders must be directed by the care manager at an AMH+ practice, CMA, or Tailored Plan. The care manager and the care management supervisor must be able to direct all care management supports for members in order to ensure that all services are well coordinated. The Extender cannot work for the same organization where they receive services. The Department expects that a range of individuals will be able to meet these qualifications, including, but not limited to:

a. Certified Peer Support Specialists;
b. Community health workers (CHW), defined as individuals who have completed the NC Community Health Worker Standardized Core Competency Training (NC CHW SCCT);
c. Individuals who served as Community Navigators prior to the implementation of Tailored Plans;
d. Family Navigators,
e. Parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition (parent/guardian cannot serve as an extender for their own family member,); and
f. A person with lived experience with an I/DD or a TBI or a behavioral health condition

v. The PIHP shall designate a Foster Care point of contact for the purposes of facilitating connections between PIHP-based care managers, PCCM care managers, county child welfare workers, and AMH+/CMA care managers (as appropriate) for children/youth in foster care/adoption assistance and former foster youth. As long as all responsibilities defined in this Contract are fulfilled, this point of contact may be a PIHP staff who may also fulfill another role in the PIHP. PIHP Organizational Roles and Positions. This point of contact shall be in place until the Department launches the Child and Families Specialty Care Plan and:

1. Be responsible for maintaining up-to-date records and contact information for the assigned care manager, the PCCM care manager, and the county child welfare worker.
2. Be available to facilitate connections between any parties involved in the Member's care.
3. Hold a Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area and have familiarity with the North Carolina child welfare system.

vi. The PIHP shall ensure all care managers, care manager extenders and supervising care managers serving its members, whether based at the PIHP, AMH+ or CMA, are trained on all the topics described in this Section.

vii. The PIHP shall develop and implement a care management training curriculum that includes the following domains at a minimum, in addition to any training requirements specified in N.C. G. S. § 122c-115.4. The PIHP care management training curriculum may be shared across the PIHP and BH I/DD Tailored Plan, as described in *Section IV.G.2. Tailored Care Management of the BH I/DD Tailored Plan Contract*, so long as it incorporates the additional training requirements for care managers and supervisors serving members in foster care/adoption assistance and former foster youth.

1. PIHP eligibility and services
   i. PIHP eligibility criteria, services available through PIHPs, and differences between Standard Plan and PIHP benefit packages.
   ii. Principles of integrated and coordinated physical and BH care and I/DD and TBI services.

iii. BH crisis response.
iv. Understanding HCBS and available services.
v. Eligibility, assessment, and coordination of 1915(i) service including:
    a. Process for conducting the state-designated assessment for individuals whose physical, cognitive, or mental conditions trigger a potential need for 1915(i) home and community-based services and supports,
    b. Knowledge of available resources, service options, providers,
    c. Requirements for ongoing coordination and monitoring of 1915(i) services, and
    d. Best practices to improve health and quality of life outcomes (42 C.F.R. § 441.730(c).

2. Knowledge of Innovations and TBI waiver eligibility criteria Whole-person health and unmet resource needs
    i. Understanding and addressing ACEs, trauma, and trauma-informed care.
    ii. Understanding and addressing unmet health-related resource needs, including identifying, utilizing, and helping the Member navigate available social supports and resources at the Member's local level.
    iii. Cultural and Linguistic Competency, including member ability, considerations for tribal populations, nonwhite populations, and forms of bias that may affect PIHP Members.
3. Community integration
    i. Independent living skills.
    ii. Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities.
    iii. Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community.
    iv. Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.
4. Components of Health Home care management
    i. Health Home overview, including but not limited to Health Homes' purpose, target population, and services, in addition to Members and their families' role in care planning.
    ii. Working effectively with a multidisciplinary care team, scheduling team meetings, planning agendas, and facilitating meetings.
5. Health promotion
    i. Providing education on members' chronic conditions.
    ii. Teaching self-management skills and sharing self-help recovery resources.
    iii. Conducting medication reviews and regimen compliance.
    iv. Promoting wellness and prevention programs.
6. Other care management skills
    i. Transitional care management best practices.
    ii. Supporting health behavior change, including motivational interviewing.
    iii. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs.
    iv. Preparing Members for and assisting them during emergencies and natural disasters.
    v. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices, particularly for members receiving care in the home or community settings, or as Members transition across care settings.
    vi. General understanding of virtual (e.g., Telehealth) applications to assist Members in using the tools.
    vii. Understanding needs of the justice-involved population.

viii. Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible members, such as PACE.
ix. Ethics, boundaries, and personal safety, including confidentiality, informed consent, mandated reporting, protected health information, HIPAA, and ensuring personal safety when entering someone's home.
x. Building a trusting relationship, including member relations and communication and conflict resolution.

7. Additional trainings for care managers, care manager extenders and supervisors serving Members with I/DD or TBI
   i. Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers.
   ii. Understanding HCBS, related planning, and 1915(c) services and requirements.
   iii. Accessing and using assistive technologies to support individuals with I/DD and TBI.
   iv. Understanding the changing needs of individuals with I/DD and TBI as they age, including when individuals transition from primary school to secondary school and age out of school-related services.
   v. Educating Members with I/DD and TBI about consenting to physical contact and sex.
8. Additional trainings for care managers, care manager extenders and supervisors serving children
   i. Child- and family-centered teams.
   ii. Understanding of the "System of Care" approach (see Section IV.G.10. System of Care), including knowledge of child welfare, school, and juvenile justice systems.
   iii. Methods for effectively coordinating with school-related programming and transition-planning activities.
9. Additional training for care managers, care manager extenders and supervisors serving the children with complex needs: Specialized training in addressing co-occurring mental health disorders and I/DDs.
10. Additional trainings for care managers, care manager extenders and supervisors serving pregnant and postpartum women with SUD or with SUD history: best practices for addressing the needs of pregnant and postpartum women with SUD or with SUD history, such as general knowledge about pregnancy, medication-assisted treatment, SUD and breastfeeding, and infant opioid withdrawal.
11. Additional trainings for care managers, care manager extenders and supervisors serving Members with LTSS Needs: Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission.
12. Additional trainings for care managers, care manager extenders, and supervisors serving Members in foster care/adoption assistance and former foster youth:
   i. Key components of the North Carolina child welfare system, including the role of local Departments of Social Services and County Child Welfare Workers;
   ii. Coordination with County Child Welfare Workers;
   iii. Medication management for Members in foster care/adoption assistance and former foster youth;
   iv. Incorporating foster parents, biological/adoptive parents, and kinship caregivers into the care planning process, as appropriate; and
   v. Resources for youth aging out of foster care.
13. Services available from the Quitline benefit, as well as the evidence-based tobacco use treatment brief intervention known as the 5As. 5As training covers screening, brief

interventions, and referral to treatment for tobacco use disorder, and covers the standard of care for tobacco treatment (a combination of counseling and FDA approved tobacco treatment medications) and

14. The State "System of Care" training curriculum (for care managers with assigned members age three (3) up to age eighteen (18) with BH needs).
15. To ensure care manager extenders are sufficiently prepared and capable to perform their duties, care manager extenders' training must include practical training modalities and evaluation, which may include role play, use of call scripts, and practice sessions.

viii. As a best practice, the PIHP may collaborate with other PIHPs, BH I/DD Tailored Plans, and any Tailored Care Management organization it sees appropriate, on Tailored Care Management curriculum development.

ix. The PIHP shall allow care managers, care manager extenders and supervisors, regardless of the organization in which they provide care management, to waive components of the required training if the care manager or supervisor can verify that they have previously completed and demonstrated competency in a specific training domain.

x. The PIHP must document and get approval for their approach to waiving components of the required training in their Care Management and Care Coordination Policy. (*Section IV.G.8. Care Management and Care Coordination Policy*).

xi. The PIHP must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.

xii. The PIHP shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.

xiii. The PIHP shall ensure that care managers, care manager extenders and supervisors complete the below core modules before being deployed to serve members;

1. Care managers, care manager extenders, and supervisors must complete all required training modules within thirty (30) Calendar Days of being deployed to serve members.
    i. The core modules are:
        a. Tailored Plan eligibility criteria, services available through Tailored Plans, and differences between Standard Plan and PIHP benefit packages;
        b. Principles of integrated and coordinated physical and BH care and I/DD and TBI services;
        c. Knowledge of Innovations and TBI waiver eligibility criteria; and
        d. Tailored Care Management overview, including but not limited to the model's purpose, target population, and services, in addition to enrollees and their families' role in care planning

xiv. Current Innovations waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.

xv. The PIHP shall provide training to its Network providers about Tailored Care Management.

xvi. The PIHP shall not require care managers, care manager extenders and supervisors working in multiple PIHP catchment areas to complete and pass each required domain of the Tailored Care Management training curriculum more than once. Care managers and supervisors should complete and pass the training in the catchment area where they serve the most members.

xvii. The PIHP may require care managers, care manager extenders and supervisors to complete additional training, beyond the required domains, specific to their catchment area or the populations they serve.

xviii. As part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*), the PIHP shall submit to the Department its Tailored Care Management training plan for approval:

1. Policies and procedures for training and qualification of care managers, supervising care managers, care manager extenders and other multidisciplinary team members;
2. Training modalities (e.g., in-person versus online);
3. Approach to tracking and verifying that care managers have completed trainings;
4. Process for addressing noncompliance with trainings;
5. Timing/frequency of trainings;
6. Summary of curriculum;
7. Approach for assessing competencies;
8. Approach for annual refreshers and ongoing continuing education; and
9. Approach for waiving specific training domains for care managers and supervisors.

xix. Additional Tailored Care Management Requirements for Members Participating or Eligible to Participate in Transitions to Community Living:

1. Tailored Care Management shall incorporate all care coordination activities, as required in the TCL settlement agreement.
2. For members participating or eligible to participate in TCL, referrals shall be made to the Department's designated tool or system (currently the Referral Screening and Verification Process (RSVP) tool) and then shall be screened by an independent screener who is employed by or on behalf of the responsible PIHP to determine whether the individual meets eligibility requirements for diversion and TCL. Eligibility requirements include Medicaid or Medicaid eligible due to income being equal to or less than the established income threshold, verified SMI/SPMI, unstable housing, and at risk of entering an ACH with accompanying evidence, such as an FL2 or application to a specific ACH.
3. The PIHP outreach team shall provide TCL members education about housing options and the choice to remain in the community, and services and supports in the community. The PIHP also shall initiate community integration planning and inform the member of available rental subsidies.

yyy. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, q. Tailored Care Management Data System Requirements, Data Sharing, and Risk Stratification, i. Tailored Care Management Data Systems Requirements, 2., vii.* is revised and restated as follows:

vii. Allow care managers to:

i. Identify risk factors for individual Members;
ii. Develop actionable Care Plans and ISPs;
iii. Monitor and quickly respond to changes in a Member's health status;
iv. Track a member's referrals and provide alerts where care gaps occur;
v. Monitor a member's medication adherence;
vi. Transmit and share reports and summary of care records with care team members; and
vii. Support data analytics and performance.

zzz. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, q. Tailored Care Management Data System Requirements, Data Sharing, and Risk Stratification, ii. Data Sharing in Support of Tailored Care Management, 1.* is revised and restated as follows:

1. The PIHP shall provide data to AMH+ practices and CMAs to support Tailored Care Management. The PIHP shall follow NCDHHS requirements for data sharing outlined in the AMH+ & CMA Program Technical & Data Requirements document. This document has posted in the Prepaid Health Plan Data Utility (PCDU) tool.

aaaa. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, q. Tailored Care Management Data System Requirements, Data Sharing, and Risk Stratification, ii. Data Sharing in Support of Tailored Care Management, 8.* is revised and restated as follows:

8. The PIHP shall make best efforts to adopt standardized data-sharing formats and protocols as advised by the Department.

bbbb. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, q. Tailored Care Management Data System Requirements, Data Sharing, and Risk Stratification, ii. Data Sharing in Support of Tailored Care Management, 10.* is revised and restated as follows:

10. The PIHP shall setup an onboarding process for AMH+ and CMA practices and will work with them to ensure they clearly understand the technical requirements they need to follow to develop all the data interfaces specified in the AMH+ and CMA data sharing requirements. The PIHP will work with Tailored Care Management Providers to guide them through the development phase, share any test files and perform integration testing prior to start sharing and receiving production data with them.

cccc. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, q. Tailored Care Management Data System Requirements, Data Sharing, and Risk Stratification, iii. Risk Stratification, 2., xviii.* is revised and restated as follows:

xviii. Results/scores of level-of-care determination and screening tools e.g., ASAM, CANS, ANSA, and SIS® (to the extent available) and other tools, as recommended by the Department;

dddd. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, t. Certification of AMH+ Practices and CMAs, iii., 2.* is revised and restated as follows:

2. During Readiness Review, the PIHP or a designated Department contracted vendor may determine that the AMH+ practice or CMA (or CIN or Other Partner on behalf of such organizations) is not ready to meet the requirements of the Tailored Care Management model. In this situation, the PIHP shall provide reasons to the Department why it proposes to decline to contract with that AMH+ practice, CMA or CIN or Other Partner, inclusive of technical assistance provided and why the AMH+ practice, CMA or CIN or Other Partner is inadequate. For the purposes of calculating compliance with the requirement to contract with all certified AMH+ practices and CMAs, the Department reserves the right not to remove an AMH+ practice or CMA from the denominator of the calculation if it deems the PIHP's reasons for not contracting to be unsatisfactory.

eeee. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, vii. Duplication of Care Management* is revised and restated as follows:

vii. Duplication of Care Management
   1. The PIHP shall ensure that a Member does not receive duplicative care management services and Providers do not receive payment for duplicative services.
   2. The Department has determined that case management provided through ACT, ICF-IIDs, and care management provided through the High-Fidelity Wraparound program, Child ACT, Critical Time Intervention, care management provided through long stay SNFs, and PACE CAP C and CAP DA are duplicative of Tailored Care Management.
   3. The Department will review In Lieu of Services request submission to determine whether the service is duplicative of Tailored Care Management. Service duplication determination will be reported to the health plan by DHHS upon approval or rejection of the ILOS request submission.
   4. If a member is receiving a duplicative service, the PIHP is responsible to ensure aspects of Tailored Care Management that are not covered by the duplicative service are still provided by the PIHP.

5. When a Member is receiving a service besides one listed in *Section IV.G. Care Management and Care Coordination* that has potential for duplication with Tailored Care Management, the PIHP and the Provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
6. If a Member enrolls in duplicative services, the PIHP must deny claims submitted by Providers for Tailored Care Management.
7. The PIHP shall submit its policies and procedures for ensuring Members do not receive duplicative care management from multiple sources as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).

ffff. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, xv.* is revised and restated as follows:

xv. In the event of continued underperformance by an AMH+ practice, a CMA or a CIN or Other Partner that is not corrected after the time limit set forth on the CAP, and the PIHP terminates its contract with the AMH+ practice, CMA, CIN, or other entity, then the PIHP shall notify the Department within seven (7) Calendar Days of initiating contract termination that it will no longer be contracting with the AMH+ practice, CMA or CIN or Other Partner for Tailored Care Management. The Department reserves the right to specify the timing and format of this notification.

gggg. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management* is revised to add the following:

xviii. In Contract Year 1, the PIHP should not condition Tailored Care Management contracts on audits and other monitoring activities that go beyond what is necessary for a practice to meet Tailored Care Management requirements. PIHPs are able to work with Tailored Care Management providers by mutual agreement to prepare for NCQA pre-delegation auditing or to otherwise build care management capacity.

hhhh. *Section IV. Scope of Services, G. Care Management and Care Coordination, 3. Care Coordination and Care Transitions for All Members, a.* is revised and restated as follows:

a. The PIHP shall be responsible for care coordination and care transitions for its Members in accordance with 42 C.F.R. § 438.208, N.C. General Statute § 122c- 115.4, and the scope of this contract, regardless of whether a Member opts out of Tailored Care Management, does not engage in Tailored Care Management, or is ineligible for Tailored Care Management.
   i. The PIHP will make best efforts to ensure facilities within its network will allow access onsite and electronically to members, facility electronic medical records, and team meetings. The members and the tailored care manager will lead the discharge and transition team meetings. The tailored care manager will actively connect member to all community-based services and supports with the assistance of the facility staff assigned to discharge and transition.

iiii. *Section IV. Scope of Services, G. Care Management and Care Coordination, 3. Care Coordination and Care Transitions for All Members, f.* is revised and restated as follows:

f. The PIHP shall employ a sufficient number of dedicated housing specialist(s) with knowledge, expertise and experience to engage public housing authorities, private landlords, state and federal housing agencies entities to develop, gain access to, rehabilitate , and otherwise generate housing stock and access with priority for members, and to act as advisors on affordable and supportive housing programs for care managers and all Members, consistent with the Department's expectation that PIHPs will play an integral role in the State's supportive housing approach utilizing a Housing First model; community integration initiatives for individuals with mental illness, I/DD and/or substance use disorders; and

requirements as outlined in *Section IV.D. Stakeholder Engagement and Community Partnerships*. The housing specialist(s) may be shared for both this Contract and the BH I/DD Tailored Plan Contract.

jjjj. *Section IV. Scope of Services, G. Care Management and Care Coordination, 5. Care Coordination Responsibilities for Members with an Unmet BH I/DD, or TBI-Related Need Who Are Not Engaged in Tailored Care Management* is revised to add the following:

d. For members with special health care needs who opt out or are not engaged in Tailored Care Management, the PIHP shall perform care coordination functions as required by 42 C.F.R. § 438.208(c).

kkkk. *Section IV. Scope of Services, G. Care Management and Care Coordination, 8. Care Management and Care Coordination Policy, c., viii., 2.* is revised and restated as follows:

2. Variation in care management comprehensive assessment based on population including:
   a. For members obtaining State Plan LTSS besides 1915(i) services, and
   b. For members obtaining 1915(i) services, the approach to incorporating independent assessment with the member's care management comprehensive assessment.

llll. *Section IV. Scope of Services, G. Care Management and Care Coordination, 8. Care Management and Care Coordination Policy, c., ix.* is revised and restated as follows:

ix. Policies and procedures for Care Plan/ISP development with members who are engaged in Tailored Care Management, including:
   1. Approach for involving multidisciplinary care team;
   2. Approach for ensuring that Care Plans/ISPs are individualized and person-centered and that the member and the member's family, advocates, caregivers, and/or legal guardians are actively involved;
   3. Process for and frequency of Care Plan/ISP updates;
   4. Approach for ISP development for members enrolled in the Innovations waiver;
   5. Approach for Care Plan/ISP development for members obtaining 1915(i) services as required by 42 C.F.R. § 441.725; and
   6. Audits of Care Plan/ISP to ensure they meet quality expectations.

mmmm. *Section IV. Scope of Services, G. Care Management and Care Coordination, 8. Care Management and Care Coordination Policy, c., xv., 1.* is revised and restated as follows:

1. Policies and procedures for training and qualification of care managers, supervising care managers, care manager extenders and other multidisciplinary team members (e.g., care manager extenders);

nnnn. *Section IV. Scope of Services, G. Care Management and Care Coordination, 10. In-Reach and Transition from Institutional Settings, c., iii.-vi.* is revised and restated as follows:

iii. Engage with the member and the member's family and/or guardians through frequent face to face meetings. Frequency of such face to face meetings should be determined on a case by case basis, but shall occur no less than twice every ninety (90) Calendar Days.

iv. Facilitate and accompany the Member and their family members and/or guardians on visits to community-based services.

v. Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing. The PIHP will maintain a monthly Local Barriers Committee (LBC) meeting that is cross-functional and includes Departmental standing representation along with their Local Ombudsman to report and solve any barriers to transition in individual member situations and/or systemic barriers affecting transition. The PIHP will submit a quarterly local barriers report ; and

vi. To the maximum extent possible, explore and address the concerns of the Member and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for supportive housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns. For Members who decline the opportunity to transition, the PIHP shall:
    1. Continue to engage the Member and/or their family members or guardians about the opportunity to transition to a more integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department.
    2. Clearly document in the Informed Decision Making Tool (IDM) that the Member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the Member of available community services, including supportive housing.

oooo. *Section IV. Scope of Services, G. Care Management and Care Coordination, 10. In-Reach and Transition from Institutional Settings, c., x.* is revised and restated as follows:

x. For Members residing in an ACH or state developmental center, and Members age 18 and over residing in a state psychiatric hospital and who have been identified for transition, refer the member to a PIHP transition coordinator, the member's care manager in the Tailored Care Management model, and DSOHF Admission Through Discharge Manager for transition services (see *Section IV.G.10. In-Reach and Transition from Institutional Settings*) and ensure a timely, Warm Handoff to the transition staff or care manager in the Tailored Care Management model that the PIHP assigns to the Member.

pppp. *Section IV. Scope of Services, G. Care Management and Care Coordination, 10. In-Reach and Transition from Institutional Settings, d., ii.* is revised and restated as follows:

ii. Collaborate with the following individuals, specialists, and provider types as applicable depending on the Member's needs, participating in all transition meetings, either by phone or in person to ensure effective and timely discharge and transition to community:
    1. The Member and/or the Member's family or guardian;
    2. Facility providers;
    3. Facility discharge planners;
    4. The Member's care manager;
    5. The Member's community-based PCP;
    6. Peer support specialist or other individuals determined to have appropriate shared lived experience;
    7. Educational specialists;
    8. The RN and OT who have assessed the medical and functional needs of the member being transitioned into housing; and
    9. Other community providers and specialists as appropriate in the transition planning process, including physical health providers, BH providers, and I/DD and/or TBI providers.

qqqq. *Section IV. Scope of Services, G. Care Management and Care Coordination, 10. In-Reach and Transition from Institutional Settings, d., xii.* is revised and restated as follows:

xii. Assess settings that the Member is transitioning to, using IDM Tool approved by the Department as described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*.

rrrr. *Section IV. Scope of Services, G. Care Management and Care Coordination, 10. In-Reach and Transition from Institutional Settings, d., xv.* is revised and restated as follows:

xv. For Members residing in a state psychiatric facility whose Medicaid eligibility is in suspended status, work with the Department and the county DSS to ensure Medicaid eligibility is active upon or soon after discharge.

ssss. *Section IV. Scope of Services, G. Care Management and Care Coordination* is revised to add the following:

11. Additional Tailored Care Management Requirements for Members Obtaining 1915(i) Services
    a. Tailored Care Management shall incorporate all 1915(i) care coordination activities, namely requirements for an independent assessment and development of a person-centered Care Plan/ISP, as required by 42 C.F.R. § 441.720 and 42 C.F.R. § 441.725.
    b. The PIHP shall notify an organization providing Tailored Care Management when one of its assigned members requests or would benefit from 1915(i) services so that the organization can commence the independent assessment.
    c. The PIHP shall share the results of the independent evaluation for 1915(i) services with the assigned organization providing Tailored Care Management in an electronic format.
        i. The PIHP shall ensure that the assigned organization performing Tailored Care Management incorporates the results of the independent assessment into the Care Plan/ISP
        ii. The completion of the independent assessment does not trigger a full care management comprehensive assessment and may be an addendum or an update to a previous care management comprehensive assessment.
        iii. The PIHP shall ensure that at a member's annual reassessment, as described in *Section IV.G. Care Management*, the independent assessment for 1915(i) services is included as part of the broader care management comprehensive assessment .
12. Additional Care Coordination Functions for Members Obtaining 1915(i) Services
    a. For members who are not engaged in Tailored Care Management when it is determined they may benefit from 1915(i) services, the PIHP shall:
        i. Conduct outreach to the member to inform the member that to obtain 1915(i) services, they have the choice of engaging in Tailored Care Management or obtaining care coordination services through the PIHP.
            1. For members who have not opted out of Tailored Care Management, the PIHP shall make best efforts to engage the member in Tailored Care Management encompassing 1915(i) care coordination.
        ii. In cases where a member obtaining 1915(i) services opts out of Tailored Care Management, the PIHP must provide care coordination for the 1915(i) services, including meeting requirements for conducting the independent assessment and development of Care Plans/ISPs required by 42 C.F.R. § 441.720 and 42 C.F.R. § 441.725.
            1. The PIHP shall ensure that care coordination for 1915(i) services is performed by a care manager meeting the qualifications described in *Section G. Care Management and Care Coordination*.
            2. The Department will not make a Tailored Care Management payment to the PIHP for members who opt out of Tailored Care Management.
    b. For all members obtaining 1915(i) services, regardless of whether they engage in Tailored Care Management, the PIHP shall ensure that care coordination includes:
        i. Conducting the independent assessment using a Department-designated tool to determine need for specific 1915(i) services. The PIHP shall comply with any additional guidance released by the Department on the Department-designated tool to conduct the independent assessment.

ii. Guiding the development and submission of the Care Plan/ISP, based on assessed need and living arrangements, at least annually:
    1. The PIHP shall ensure that the member's care manager convenes a person-centered planning meeting and completes the Care Plan/ISP in line with federal requirements 42 C.F.R. § 441.725. This is done after the member is administered the independent assessment for initial plans of care.
    2. If applicable, the PIHP shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the Care Plan/ISP to the PIHP.
    3. The PIHP shall review Care Plan/ISP for compliance with 1915(i) SPA requirements, medical necessity, and the member's health and safety needs.
    4. The PIHP shall approve or deny the Care Plan/ISP within standard service authorization periods except for in the case of initial plans, which must be received within sixty (60) Calendar Days of 1915(i) eligibility determination.
    5. In the case where services are immediately needed, an interim plan of care may be completed so that services may be approved with the full Care Plan/ISP being completed afterwards and within the sixty (60) Calendar Days of eligibility determination for 1915(i) services. Immediately needed 1915(i) services may include, but are not limited to, 1915(i) services that a member needs in order to:
        a. Facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting;
        b. Prevent imminent placement outside the person's current living arrangement;
        c. Address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm; or
        d. Prevent imminent loss of competitive integrated employment or an offer of such employment.
    6. The PIHP shall ensure that 1915(i) services begin within forty-five (45) Calendar Days of Care Plan/ISP approval.
iii. Monitoring requirements found in the 1915(i) SPA.
iv. Explaining the service authorization process
v. Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the Care Plan/ISP, including providing a list of available providers and arranging provider interviews
vi. Monitoring Care Plan/ISP goals at a minimum frequency based on the target date assigned to each goal
vii. Maintaining close contact with the member/LRP (if applicable), providers and other members of the Care Plan/ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner
viii. Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the member as required by 42 C.F.R. § 441.710(a)(1)(i)
ix. Completing the independent assessment prior to the development of the Care Plan/ISP and updating at least annually or as significant changes occur with the member as required by 42 C.F.R. § 441.720(b)
x. Providing timely notification to PIHP utilization management of updates to eligibility for 1915(i) services and timely processing of updates to the Care Plan/ISP
xi. Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan
xii. Monitoring of service delivery to verify that:

1. At least one (1) 1915(i) service is utilized at a frequency determined by the Department in the 1915(i) SPA as required by 42 C.F.R. § 441.710(c).
2. Services are furnished in accordance with the Care Plan/ISP.
3. Member is offered a choice of 1915(i) service providers.
4. Member has access to services and supports that meet the member's needs.
5. Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-1915(i) service needs (medical care) are addressed and documented as appropriate.
6. 1915(i) services utilized do not exceed authorization.
7. Member is satisfied with the services being rendered.

c. The PIHP shall monitor service utilization to remain within service authorizations.

d. The PIHP shall notify the member's provider and AMH+ practice or CMA (if applicable) of utilization decisions.

tttt. *Section IV. Scope of Services, H. Providers, 1. Provider Network, b. Availability of Services (42 C.F.R. § 438.206), vi. SUD Residential Treatment Services, 1.* is revised and restated as follows:

1. PIHPs shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VI. First Revised and Restated Attachment F. Required Standard Provisions for PIHP and Provider Contracts*.

uuuu. *Section IV. Scope of Services, H. Providers, 1. Provider Network, b. Availability of Services (42 C.F.R. § 438.206)* is revised to add the following:

vii. 1915(i) Services

1. The PIHP Plan shall ensure that 1915(i) service providers comply with HCBS standards as set forth in 42 C.F.R. § 441.730 and requirements set forth by the Department.
2. Provider agencies shall comply with the applicable provider specifications for services set forth in the 1915(i) SPA.
3. National accreditation is required of most providers of 1915(i) services per the 1915(i) SPA. Upon contracting with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the waiver(s). The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

vvvv. *Scope of Services, H. Providers, 2. Provider Network Management, c. Provider Contracting, iii,* is revised and restated as follows:

iii. Any change to as standard provision required by *Section VI. Attachment F. First Revised and Restated Required Standard Provisions for PIHP and Provider Contracts*, is limited to those provisions outlined in *Section VI. Attachment F. First Revised and Restated Required Standard Provisions for PIHP and Provider Contracts, a.,* except for a change to a provision located within *subsection a.xxv. Miscellaneous Provisions*. Changes to provisions located within *subsection a.xxv. Miscellaneous Provisions* require the Department's written approval prior to making changes.

wwww. Se*ction IV. Scope of Services, H. Providers, 2. Provider Network Management, c. Provider Contracting, iv,* is revised and restated as follows:

iv. Reserved.

xxxx. Sec*tion IV. Scope of Services, H. Providers, 2. Provider Network Management, c. Provider Contracting, vii,* is revised and restated as follows:

vii. The PIHP may only make changes to the provisions required in Section ~~3~~ b. of *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*, when directed to do so by the Department.

yyyy. Sec*tion IV. Scope of Services, H. Providers, 2. Provider Network Management, c. Provider Contracting, ix.* is revised and restated as follows:

ix. The PIHP shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract. This validation should be done at least monthly thereafter.

1. If the PIHP is made aware of providers included in their network file that are not actively enrolled in NC Medicaid, the PIHP shall remove the provider from the PIHP network File within one (1) Business Day of notification. The PIHP shall remove any provider from the PIHP Network File and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider.

zzzz. Sec*tion IV. Scope of Services, H. Providers, 2. Provider Network Management, c. Provider Contracting, xxv.* is revised and restated as follows:

xxv. For any provider subject to a rate floor as outlined in *Section IV.H.4. Provider Payments*, a PIHP may include a provision in the provider's contract that the PIHP will pay the lesser of billed charges or the rate floor only if the provider and the PIHP have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision, with the exception of the Durable Medical Equipment and the Physician Administered Drug Program rate floor. A PIHP shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

aaaaa. Sec*tion IV. Scope of Services, H. Providers, 2. Provider Network Management, i. Network Provider System Requirements, v. Network Contracting Decisions, 2.* is revised and restated as follows:

2. Reserved.

bbbbb. Sec*tion IV. Scope of Services, H. Providers, 2. Provider Network Management, i. Network Provider System Requirements, viii. Provider Directory, 7., xiv.* is revised and restated as follows:

xiv. Whether provider serves Medicaid beneficiaries;

ccccc. Sec*tion IV. Scope of Services, H. Providers, 3. Provider Relations and Engagement, c., v., 2.* is revised and restated as follows:

2. Reserved.

ddddd. Sec*tion IV. Scope of Services, H. Providers, 3. Provider Relations and Engagement, d. Provider Manual* is revised to add the following:

x. The PIHP shall make the redline provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal only.

eeeee. Se*ction IV. Scope of Services, H. Providers, 3. Provider Relations and Engagement, f. Provider Recruitment, x., 1.* is revised and restated as follows:

1. The PIHP shall submit recruitment materials to the Department at least ninety (90) Calendar Days before the proposed use of the material.

fffff. Se*ction IV. Scope of Services, H. Providers, 4. Provider Payments, d. Physician and Physician Extender Payments* is revised to add the following:

iii. Beginning April 1, 2023, the PIHP shall reimburse Opioid Treatment Programs no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or bundle, as set by the Department, unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.

ggggg. Se*ction IV. Scope of Services, H. Providers, 4. Provider Payments, i. Payment to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management* is revised and restated as follows:

i. Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management
    i. For Tailored Care Management, the PIHP shall pay AMH+ practices and CMAs;
    ii. Tailored Care Management payment for each Medicaid month in which the AMH+ practice or CMA performed Tailored Care Management for each member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. This Tailored Care Management payment shall not be placed at risk. The PIHP shall pay AMH+ practices or CMAs the Tailored Care Management payment for any month in which the Medicaid member is assigned to the AMH+/CMA and the AMH+/CMA delivers at least one (1) care management contact. The PIHP shall not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one (1) care management contact, even if the AMH+/CMA has not delivered the minimum number of contacts during the month based on the member's acuity tier; and
        1. Performance incentive payment, if earned by the AMH+ or CMA. The performance incentive payment shall be based on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual, once released.
        2. Prior to the release of AMH+ and CMA metrics in the Department's Technical Specifications Manual, the PIHP may, but is not required to make, performance incentive payments to AMH+ or CMAs for Tailored Care Management. The Department encourages the PIHP to base any performance incentive payment payments on the Tailored Plan measure set and Medicaid Quality Strategy. Following the release of AMH+ and CMA metrics, the PIHP must offer performance incentives payments to AMH+ and CMAs and base these performance incentive payment on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual.
    iii. Only contacts delivered by the assigned care manager or care manager extender shall count towards meeting the contact requirements described in *Section IV.G.2.* and be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a contact to a member, the contact shall count towards meeting contact requirements and be eligible for payment.

hhhhh. S*ection IV. Scope of Services, H. Providers, 4. Provider Payments, k. Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)* is revised and restated as follows:

k. Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)

i. With the exception of out-of-network emergency services, post-stabilization services and services provided during transitions in coverage, the PIHP shall be prohibited from reimbursing an out-of-network provider more than ninety percent (90%) of the Medicaid Fee for Service rate if the PIHP has made a good faith effort to contract with the provider, but the provider has refused that contract.

ii. The PIHP shall develop Good Faith Provider Contracting Policy that includes a description of how the PIHP will conclude that a "good faith" contracting effort has been made. The PIHP shall submit the policy to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Good Faith Provider Contracting policies and procedures clearly state they apply to the PIHP, Good Faith Provider Contracting policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

1. The PIHP shall consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.
2. The PIHP shall include in its Good Faith Contracting Policy a description of the outreach program to providers that the PIHP, and its subcontractors as applicable, will utilize when leveraging one of the PIHP's existing Medicaid program's Networks to build a new program's Network. PIHP's outreach program shall be added to the PIHP's Good Faith Contracting Policy no later than March 15, 2023. The PIHP shall update the Policy whenever there are significant changes to the outreach program.

iii. The PIHP shall reimburse an out-of-network provider who is providing services to a member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid Fee for Service rate the predominant rate [as established by LME/MCO] for applicable behavioral health service.

iv. Unless an agreement has been negotiated, the PIHP shall reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee for Service rate for: BH,I/DD, and TBI services when the PIHP has not made a "good faith" effort as defined in the Contract with the provider in accordance with the PIHP's Good Faith Provider Contracting Policy or the PIHP has exercised its authority to maintain a closed network for these services as set forth in N.C. Gen. Stat. § 108D-23.

v. The PIHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee for Service rates specified in SPAs 4.19-A and 4.19-B (Medicaid) when the services meet any of the following criteria:

1. Are more reasonably available than can be provided by an in-state Network provider; or
2. The care and services are provided in any one of the following situations:
   i. In response to an Emergency Medical Condition;
   ii. The health of the member would be endangered if the care and services were postponed until the member returns to North Carolina; or
   iii. The health of the member would be endangered if travel were undertaken to return to North Carolina.

vi. In accordance with 42 C.F.R. § 438.206(b)(5), the PIHP shall coordinate payment with the out-of-network provider to ensure that the cost to the member is no greater than it would be if services were provided by a provider in the Network.

iiiii. Se*ction IV. Scope of Services, H. Providers, 4. Provider Payments* is revised to add the following:

n. The PIHP shall not use the Outpatient Prospective Payment System (OPPS) to reimburse institutional hospital outpatient claims including lab and drug claims.

o. ICF/IDD Provider Payments

i. Beginning April 1, 2023, the PIHP shall increase reimbursement rates to eligible community based ICF/IID providers by amounts prescribed by the Department. The PIHP shall implement the reimbursement rates consistent with the timeline requirements of *Section IV.J.1.d.iv.4)*. For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section IV.J.1.d.iv)*.

1. The Department shall maintain and share with the PIHP a list of eligible providers, the applicable increase for each provider, and the time period (by dates of service) for which each provider is eligible for the enhanced reimbursement amount in the PCDU. Enhanced reimbursement amounts may vary by provider.
2. The PIHP shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to certain providers for dates of service specified by the Department to account for any changes to provider eligibility for all or a portion of the enhanced reimbursement.
3. The PIHP shall communicate to contracted providers that enhanced reimbursement amount is contingent on eligibility for ICF/IID Direct Care Worker wage-related reimbursement increases maintained by the Department

p. HCBS Direct Care Worker Wage Increases

i. Beginning April 1, 2023, the PIHP shall increase reimbursement rates to eligible HCBS providers for eligible services by amounts no less than the amounts prescribed by the Department. The PIHP shall implement the reimbursement rates consistent with the timeline requirements of *Section IV.J.1.d.iv.4).* For any claims that the PIHP is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section IV.J.1.d.iv)*.

1. Reimbursement increases for State Plan services shall be no less than the per unit reimbursement increases in the North Carolina Medicaid Fee-For-Service Fee Schedule.
2. Reimbursement increases for approved in-lieu of services shall be no less than the per unit reimbursement increases communicated through Medicaid provider bulletins.

ii. The Department shall maintain and share with the PHP a list of HCBS services and codes that the rate increase will apply to through the PCDU and the DHHS Website.

iii. The PIHP shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to specific providers to account for any changes to provider eligibility for enhanced reimbursement.

iv. The PIHP shall communicate to contracted providers that the reimbursement increase is contingent on eligibility for HCBS Direct Care Worker wage-related reimbursement increases maintained by the Department.

q. Payment for Crisis Providers

The PIHP shall reimburse in-network providers for mobile crisis services and facility based crisis services no less than the Department's Enhanced Behavioral Health Fee Schedule unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.

r. Provider Hardship Payments

i. The PIHP shall process Hardship Payment requests from a provider within seven (7) Business Days of receipt of a hardship request or three (3) Business Days of receipt of an urgent hardship request.

ii. The PIHP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval within thirty (30) Calendar Days of Contract execution. The PIHP may submit a consolidated Provider Hardship Payment Policy applicable for both Medicaid Direct and BH I/DD Tailored Plan programs. The Provider Hardship Payment Policy shall include:
    1. Method for providers to submit hardship payment requests;
    2. Description of timeline for payment for standard and urgent requests, including integration into check write schedule;
    3. Criteria for requests to be reviewed and approved by the PIHP; and
    4. Description of how providers and Department will be notified of status of the request and payment, if applicable.
iii. The PIHP shall recoup Hardship Payments by offsetting the provider's future claim payments or through a one-time repayment by the provider.

s. Payment for Behavioral Health Services provided to Members awaiting hospital discharge
    i. Upon CMS approval, the PIHP shall reimburse in-network providers for Behavioral Health Services provided to Members awaiting hospital discharge as defined in the NC Medicaid State Plan and in Clinical Coverage Policy 2A-1 at no less than one hundred percent (100%) of the Medicaid Direct Fee schedule unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.

jjjjj. Se*ction IV. Scope of Services, H. Providers, 5. Provider Grievances and Appeals, a.* is revised and restated as follows:

a. The PIHP shall handle provider Appeals and Grievances promptly, consistently, fairly, and in compliance with State and federal law and Department requirements. The PIHP shall have in place a provider Appeals and Grievance system, distinct from that offered to Members, that includes a Grievance process for providers to bring issues to the PIHP, an Appeals process for providers to challenge certain PIHP decisions, and information regarding recourse available under contract or law. The PIHP shall be transparent with providers regarding its Appeals and Grievance processes and procedures. The PIHP shall ensure the Grievance and Appeals system comply with Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships, if PIHP has contracted with a Subcontractor for the Grievance and Appeals system.

kkkkk. Se*ction IV. Scope of Services, H. Providers, 5. Provider Grievances and Appeals, c.* is revised and restated as follows:

c. The PIHP shall submit the PIHP Provider Grievances and Appeals Policy to the Department for review upon request but no sooner than sixty (60) Calendar Days after Contract Execution. The PIHP shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes. As long as the Provider Grievance and Appeals policies and procedures clearly state they apply to the PIHP, Provider Grievance and Appeals policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

lllll. Se*ction IV. Scope of Services, H. Providers, 5. Provider Grievances and Appeals, j. Notice to Department* is revised and restated as follows:

j. Notice to Department
    i. The PIHP shall provide notice to the Department of any provider Appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by PIHP, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the Appeal.

ii. The PIHP shall notify Department if a provider has sued PIHP in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.

mmmmm. Se*ction IV. Scope of Services, I. Quality and Value, 1. Quality Management and Quality Improvement, d., i., 1.* is revised and restated as follows:

1. The PIHP shall submit an annual combined QAPI Plan for Medicaid delineating the PIHP's plans for performance improvement programs and other quality improvement efforts as part of the QAPI Plan due, but no later than sixty (60) Calendar Days after Contract Execution. As long as the QAPI clearly states that it applies to the PIHP, the QAPI may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.

nnnnn. Se*ction IV. Scope of Services, I. Quality and Value, 1. Quality Management and Quality Improvement, h. Quality Measures, i.* is revised and restated as follows:

i. The PIHP will be held accountable for performance on all measures listed NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website, that are meant to provide the Department with a complete picture of the PIHP's processes and performance. The PIHP's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and, financial accountability for a select set of measures to be specified by the Department.

ooooo. Se*ction IV. Scope of Services, I. Quality and Value, 2. Value-Based Payments (VBP)* is revised and restated as follows:

2. Value-Based Payments (VBP)
   a. To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value included in the PIHP Quality Strategy, the Department is requiring adoption of VBP arrangements between the PIHP and providers. The Department will issue additional guidance and details on VBP requirements for PIHPs.
   b. The Department defines VBP arrangements as payment arrangements between the PIHP and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at http://hcp-lan.org/workproducts/apm-framework-onepager.pdf. The Department reserves the right to narrow the definition of VBP and the range of acceptable PIHP VBP arrangements with providers in the future.
      i. Payments to AMH+ and CMA providers will be considered VBP only when these contracts include a performance incentive payment, as described in *Section IV.H.4. Provider Payments*.
      ii. All VBP arrangements must be aligned with the PIHP Quality Strategy and related measures.
      iii. The PIHP shall re-submit contract templates to the Department for review at least ninety (90) Calendar Days before use in the market when any new VBP arrangements (excluding to AMHs, which is covered in *Section IV.H.4. Provider Payments*), or changes to VBP arrangements, are added.
   c. The Department may set minimum targets for VBP contracting starting in Contract Year 2, and implement withholds associated with these targets. Targets will be published at least six (6) months prior to the Contract Year in which they take effect.
   d. The PIHP shall have IT infrastructure and data analytic capabilities to support the Department's vision in moving toward VBP, including having systems that can support alternative payment arrangement

models which require data-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.

e. Following the end of Contract Year 1, the PIHP shall complete an annual VBP Assessment, in a format to be determined by the Department, based on the categories developed by HCP-LAN.
    i. The Department shall use the VBP Assessment to demonstrate details about VBP contracts and compare documented progress to the PIHP's final VBP Strategy on an annual basis.
    ii. The PIHP shall report the initial results of its VBP Assessment focused on VBP contracts in place to date within ninety (90) days of the end of the Contract Year 1.
    iii. As long as the VBP Assessment clearly state it applies to the PIHP, VBP Assessment may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
    iv. The PIHP shall update the VBP Assessment on an annual basis, within ninety (90) Calendar Days of the end of each contract year.

f. To ensure the PIHP's response aligns with the Department's strategy and goals, the PIHP shall develop a PIHP VBP Strategy for Contract Years 1-3, in alignment with the Department's short- and long-term goals to shift from a fee for service system to VBP.
    i. The PIHP VBP Strategy must be submitted to the Department due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
    ii. As long as the VBP Strategy clearly state that it applies to the PIHP, the VBP Strategy may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract. and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract
    iii. All sections of the PIHP VBP Strategy must be updated on an annual basis, within ninety (90) Calendar Days of the end of each Contract Year.
    iv. The VBP Strategy shall contain the following elements:
        1. A narrative description addressing:
            i. The PIHP's goals, strategies, and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the PIHP will involve BH and intellectual and developmental disability providers in its VBP arrangements.
            ii. A description of the VBP model(s) that will be pursued by the PIHP and its providers and their HCP-LAN classification, including a description of the required performance incentive programs for AMH+ practices and CMAs, which must be consistent with requirements for Tailored Care Management payment, and a description of VBP arrangements offered to non-AMH+/CMA providers.
            iii. The PIHP's plan for measurement of outcomes and results related to VBP by year.
            iv. The PIHP's approach to address Unmet Health-Related Resource Needs as part of its VBP strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes.
            v. A description of the PIHP's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the PIHP VBP programs. Specific functionalities to address include:
                a. Risk adjustment;
                b. Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
                c. Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;

d. Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
e. Reporting capabilities; and
f. Payment functions.

vi. The PIHP's approach to address health disparities and incorporate health equity into their internal and external policies, and procedures.

2. The PIHP's projected annual targets for VBP contracts with providers in HCP-LAN Levels 1 through 4, in a format to be determined by the Department.

g. Additionally, the PIHP shall participate in any VBP stakeholder meeting process initiated by the Department. The PIHP will be responsible for meeting any requirements outlined by a Departmental VBP stakeholder group for future contract years.

ppppp. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, a.* is revised and restated as follows:

a. In order to incentivize successful delivery of Medicaid benefits and increase provider participation, the PIHP shall pay all providers on a timely basis upon receipt of any Clean Claims for covered services rendered to members who are enrolled with the PIHP in accordance with State and Federal statutes. To maximize Federal match and ensure accurate reporting, the PIHP shall comply with the Department's Managed Care Billing Guidance (commonly known as the PHP Billing Guide) or as otherwise directed by the Department.

i. When the Department releases revisions to the Managed Care Billing Guide, the PIHP shall update their systems to process new claims received within forty-five (45) Calendar Days of the Managed Care Billing Guide publish date, and reprocess impacted claims within seventy-five (75) Calendar Days of publication of this new guidance. If the PIHP is unable to update their system and reprocess claims within the seventy-five (75) Calendar Days timeline, interest and penalties shall be paid on those claims according to requirements in *Section IV.J.1.d. Interest and Penalties*.

qqqqq. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iii., 2.* is revised and restated as follows:

2. For the purposes of this requirement, the Provider is deemed eligible to be paid if they are currently enrolled as a Provider in the North Carolina Medicaid program, enrolled in the PIHP closed network and contracted with the PIHP or have a valid out of network agreement to deliver services to PIHP Members or submitting a claim for Emergency Services, are subject to an out-of-state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.

rrrrr. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iv.* is revised to add the following:

5. The PIHP shall have a no cost option for providers to select for claims submitted by electronic funds transfer (EFT) for transmission of claims through switch companies and/or clearinghouses. Requiring transaction fees, including but not limited to clearinghouse fees and electronic funds transfer (EFT) fees is prohibited. The PIHP shall provide a no-cost option for processing all claim types.

sssss. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards* is revised to add the following:

viii. The PIHP shall process and pay claims based on the codes submitted by the provider. The PIHP shall not change any data elements submitted by the provider on a claim. Nothing in this section is intended to prohibit or otherwise limit PIHP's right to deny claims for missing data elements or for lack of medical necessity.

ix. Claims Provider Validation

1. The PIHP shall validate the taxonomy code submitted on the claim against the Taxonomy Code field(s) sent for the provider on the provider enrollment file. The additional taxonomy level information provided for information purposes only on the provider enrollment file should not be used during the claim submission process.
2. The PIHP shall validate the claim's date of service against the enrolled provider's taxonomy effective dates. In the case of inpatient stays, if a provider's taxonomy status changes during a Member's stay, taxonomy effective date validation should be based on n the date of discharge for DRG based claims and should be based on the date of service for per diem claims.
3. Once validated, the PIHP shall price claims based on the taxonomy code submitted on the claim.

x. The PIHP shall use the same grouper version as the Department. Grouper updates at the Department occur annually in October, and the PIHP shall use the PHP Billing Guide to identify the current grouper version number.

ttttt. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii.* is revised and restated as follows:

iii. The PIHP 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 PIHP may not limit the time in which Claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the PIHP 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.

1. When a member is retroactively enrolled, the PIHP 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.

uuuuu. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties, 4.* is revised and restated as follows:

4. The PIHP shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website. The PIHP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates within seventy-five (75) Calendar Days of notification from the Department or the actual date of posting on the Department's website. This standard is only applicable for NC DHB rate floor programs. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section.

vvvvv. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, f. System Standards* is revised to add the following:

iii. The PIHP 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. 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 HIPAA transaction (ASC X12, 275 claim attachment format or attachment indication in an 837 with the attachment sent separately). The PIHP shall implement this capability for provider use no later than March 1, 2023. If an extension is needed, the PIHP may submit a request to the Contract Administrator for Day-to-Day Activities.

wwwww. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims* is revised to add the following:

i. Known System Issues
   i. The PIHP shall develop, maintain, and share a Known System Issues Tracker with providers through newsletters, provider portal, and/or health plan website on a weekly basis to keep providers informed on all known health plan system issues with provider impact.
   ii. The Known System Issues tracker shall include the following information at a minimum:
      1. Provider Type: type of provider(s) impacted by the system issue (e.g., hospital, pediatrics);
      2. Number of Impacted Providers: number of known providers impacted by the system issue;
      3. Category: type of system issue (e.g., claims, eligibility, provider, prior approval);
      4. Issue: detailed description of the system issue and implications. If claims related, include the estimated number of claims impacted and the estimated total billed amount;
      5. Date Issue Found: month, day, and year the PIHP identified the system issue;
      6. Number of Days Outstanding: number of days this issue has been open;
      7. Estimated Fix Date: month, day, and year the PIHP plans to have this system issue resolved;
      8. Status: status of the issue (open, ongoing, or closed);
      9. Resolution: description of the actions taken to resolve the system issue. If applicable, include claims adjustment/reprocessing timeline and make a note of resolved issues with pending adjustments/pending reprocessing. For pending adjustments, include estimated date of completion;
      10. Interest/Penalties Owed: whether interest and penalties will be applied (Yes or No); and
      11. Date Resolved: month, day, and year the PIHP resolved this system issue.
   iii. The PIHP shall maintain each item on the Known Issues Tracker for at least ninety (90) Calendar Days after resolution of the issue.
   iv. The PIHP shall include the link to the Known Issues Tracker in the Provider Manual and submit the updated deliverable to the Department no later than December 1, 2022.
j. Payer Initiated Claim Adjustment
   i. The PIHP shall have the capability to complete payer initiated claim adjustments of adjudicated claims by provider types, claim types, and time period.
   ii. The PIHP shall comply with the Departments policies and procedures on claim adjustments/reprocessing.
   iii. The PIHP shall have the capability to complete a report of adjudicated claims and provide all relevant claim data including claim number, member Medicaid number, provider NPI, and date of service.
   iv. The PIHP shall complete the adjustment report as requested by the department when a previously processed claim by the payer has been adjusted/reprocessed. There is no minimum number of claims required for the report. If an issue has been identified, all claims impacted should be corrected and included in the report.

xxxxx. *Section IV. Scope of Services, J. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency* is revised and restated follows:

e. Submission Standards and Frequency
   i. The PIHP shall submit all claims processed as encounters, as defined in this Section, and each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, accuracy, and reconciliation.

1. Timeliness
    i. Encounter data for claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.
    ii. The PIHP encounter data submissions shall meet or exceed a timely submission standard of ninety-eight percent (98%) within thirty (30) Calendar Days after payment whether paid or denied for claims.
    iii. Encounter data timeliness shall be defined as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
2. Accuracy
    i. PIHP encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
        a. Encounter data accuracy shall be defined as 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.
3. Reconciliation
    i. PIHP encounter submissions 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.
    ii. Encounter data reconciliation shall be defined as the paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PIHP.

yyyyy. *Section IV. Scope of Services, K. Financial Requirements, 1. Capitation Payments, e*. is revised and restated as follows:

e. The Department has established a separate payment outside of the capitation rate for Tailored Care Management for Members enrolled in Medicaid. This payment will be made to the PIHP for any month in which the Member is engaged in Tailored Care Management.

zzzzz. *Section IV. Scope of Services, K. Financial Requirements, 2. Medical Loss Ratio, b.* is revised and restated as follows:

b. The PIHP shall calculate and report aggregate MLR for the rating period on two (2) bases as follows:
    i. The PIHP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).
        1. For the April 1, 2023 through June 30, 2024 rating period, the PIHP shall report the CMS-defined MLR separately for April 1, 2023 through June 30, 2023 and July 1, 2023 through June 30, 2024 time periods to align with the MLR reporting year as defined in 42 C.F.R. § 438.8(b).
        2. The numerator of the PIHP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the PIHP's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
        3. The denominator of the PIHP's CMS-defined MLR for a MLR reporting year shall equal the PIHP's adjusted premium revenue. The adjusted premium revenue shall be defined as the PIHP's premium revenue minus the PIHP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).

ii. The PIHP shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.
    1. The PIHP shall report the Department-defined MLR for the entire April 1, 2023, through June 30, 2024 rating period.

iii. The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments: The PIHP is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:
    1. Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual members and North Carolina geographic areas, including rural areas.
    2. Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.
    3. The PIHP is prohibited from including in the Department-defined MLR numerator any of the following expenditures: Payments to related providers that violate the Payment Limitations as required in the Contract.
    4. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR.

aaaaaa. Section *IV. Scope of Services, K. Financial Requirements, 2. Medical Loss Ratio, c., iv* is revised and restated as follows:

iv. The PIHP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting period.

bbbbbb. *Section IV. Scope of Services, K. Financial Requirements, 2. Medical Loss Ratio, e.* is revised and restated as follows:

e. The minimum MLR threshold for the PIHP shall be eighty-five percent (85%).

cccccc. *Section IV. Scope of Services, K. Financial Requirements, 3. Financial Management, f. Financial Viability, ii. 2.* is revised and restated as follows:

2. For a PIHP to be considered viable at the time of readiness review and subsequently have their solvency plan evaluated, a PIHP must document capital reserves of at least nine percent (9.0%) of total expected annual BH I/DD Tailored Plan and PIHP Medicaid capitation combined by Day 1 of PIHP launch.

dddddd. *Section IV. Scope of Services, K. Financial Requirements* is revised to add the following:

4. Risk Corridor
    a. A risk corridor arrangement between the PIHP and the Department will apply to share in gains and losses of the PIHP as defined in this section. The Risk Corridor payments to and recoupments from the PIHP will be based on a comparison of the PIHP's reported Risk Corridor Services Ratio ("Reported Serves Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in *Section VII. Medicaid PIHP Rate Book* ("Target Services Ratio").
    b. The Risk Corridor Measurement Period is defined as April 1, 2023, to June 30, 2024.
    c. The risk corridor payments and recoupments will be based on a comparison of the PIHP's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-

setting by the Department. The Target Services Ratio will be documented in *Section VII. Medicaid PIHP Rate Book* by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.

d. The PIHP Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in *Section VII. Medicaid PIHP Rate Book* and weighted by the PIHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments and Tailored Care Management payments outside of monthly capitation).

e. The Reported Services Ratio numerator shall be the PIHP's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care program. The numerator shall be defined as the sum of:
    i. Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments.
    ii. Other quality-related incentive payments to NC Medicaid providers.
    iii. Non-claims based provider stabilization payments to support provider sustainability and beneficiary access.
    iv. Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.

f. The PIHP is prohibited from including in the Reported Services Ratio numerator the following expenditures:
    i. Payments to providers and PIHP expenses for Tailored Care Management.
    ii. Payments to providers for delegated Care Management.
    iii. Interest or penalty payments to providers for failure to meet prompt payment standards.
    iv. Payments to related providers that violate the Payment Limitations as required in the Contract.
    v. Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation.

g. The Reported Services Ratio denominator represents the Medicaid managed care revenue received by the PIHP for enrollments effective during the Risk Corridor Measurement Period excluding the separate Tailored Care Management revenue. The denominator shall be equal to the Department-defined MLR denominator.

h. PIHP shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.

i. The PIHP must provide an attestation of the accuracy of the information provided in its submitted risk corridor calculations, as specified in 42 C.F.R. § 438.606.

j. Terms of the Risk Corridor
    i. If the Reported Services Ratio is less than the Target Services Ratio minus three percent (3%), the PIHP shall pay the Department eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus three percent (3%) and the Reported Services Ratio.
    ii. If the Reported Services Ratio is greater than the Target Services Ratio plus 3%, the Department shall pay the PIHP eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus three percent (3%).

k. Risk Corridor Settlement and Payments
    i. The Department will complete a settlement determination for the Risk Corridor Measurement Period.

ii. The PIHP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
iii. The PIHP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
iv. The PIHP shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.
v. The Department may choose to review or audit any information submitted by the PIHP.
vi. The Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.
vii. The Department will provide the PIHP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to *Section V. Contract Performance* of the Contract within fifteen (15) Calendar Days of the notice by the Department to the PIHP.
viii. If the final Risk Corridor Settlement requires the PIHP to remit funds to the Department, the PIHP must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final Risk Corridor settlement.
ix. At the sole discretion of the Department, the Department may allow the PIHP to contribute all or a part of the amount otherwise to be remitted to:
    1. Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.
    2. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.
x. To be considered for the in lieu of remittance option, the PIHP must submit a proposal to the Department for review and approval concurrent with or prior to submission of the PIHP's interim Risk Corridor Services Ratio report.
xi. If the PIHP has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the PIHP by offsetting a subsequent monthly capitation payment.
xii. If the final Risk Corridor Settlement requires the Department to make additional payment to the PIHP, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final Risk Corridor settlement. If the PIHP initiates a dispute as described in *Section V. Contract Performance* the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

eeeeee. *Section IV. Scope of Services, L. Technical Specifications, 3. Enrollment and Reconciliation, c. Provider Enrollment and Credentialing* is revised and restated as follows:

c. Provider Enrollment and Credentialing
    i. The Department or a designated vendor will provide to the PIHP a daily, full file including all North Carolina Medicaid enrolled providers, including relevant enrollment, affiliation, and credentialing information.
        1. During the Provider Credentialing Transition Period, the information will be provided daily, in a format and transmission protocol to be defined by the Department.
        2. After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the PIHP a notice of change to the frequency and format not less than one hundred twenty (120) Calendar Days prior to implementation.

i. The PIHP shall reconcile provider data with the Department, or designated vendor, daily.
ii. The PIHP is responsible for notifying the Department, or designated vendor, of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
iii. The Department, or designated vendor, shall determine if corrections are needed to the provider data to address PIHP discrepancies identified during reconciliation.
iv. The PIHP shall integrate the daily enrollment file sent by the department and apply any updates to their database.
v. The Department or designated vendor will provide the PIHP with a Response File after successfully receiving the PIHP's full network directory file daily.
vi. The PIHP shall accept the Response File from the Department or designation vendor daily, work to correct any errors within twenty four (24) hours, and provide notice to the Department of any discrepancy.

ffffff. *Section IV. Scope of Services, L. Technical Specifications, 5. Provider Directory, b. Consolidated Provider Directory Data Transmission, i.* is revised and restated as follows:

i. The Department has designated a vendor to create a Consolidated Provider Directory which will include all North Carolina Medicaid enrolled providers.

gggggg. *Section IV. Scope of Services, L. Technical Specifications, 6. Technology Documents, b.* is revised and restated as follows:

b. Security Documentation: The PIHP must comply with all State and NC DHHS security policy as outlined in the State and DHHS Security manuals. These manuals are available at the following link, accurate as of February 14, 2023: https://it.nc.gov/documents/statewide-information-security-manual and https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/manuals. In compliance with this policy, the NC DHHS Privacy and Security Office and the Department of Information Technology require at a minimum three documents to be submitted by the PIHP. Two of the three documents as detailed below must be submitted using the State's templates. As long as the System Security Plan, Vendor Readiness Assessment Reports and SOC 2 Self-assessments clearly state that they apply to the PIHP, they may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.
    i. Vendor Readiness Assessment Report (VRAR) - The VRAR and its underlying assessment are intended to enable DHHS to reach a state-ready decision for a specific vendor solution, hosted on or off the State network based on organizational processes and the security capabilities of the information system. The template for the VRAR can be accessed here: https://it.nc.gov/documents/vendor-readiness-assessment-report .
    ii. System Security Plan (SSP): The PIHP shall provide a plan that details how the PIHP will comply with the Department Confidentiality, Privacy and Security Protections requirements as outlined in the Contract or in the State or NC DHHS security manuals referenced above using the template provided by the Department. After approval by the Department, the System Security Plan shall be updated annually and resubmitted to the Department for review.
    iii. SOC 2 Type II Report
        1. The PIHP must submit a completed Soc 2 Type II report per the schedule outlined below. If the technology platform used to deliver the services under this contract has not been used in a production setting prior to the go live of the PIHP, a Self-Assessment must be performed on the technology platform and submitted to the Department prior to go live, in lieu of the Soc 2 Type II.

i. The following cycle will be used to allow all PIHPs the time needed to complete the required operations observation period, and the review and reporting period prior to submission to the Department:
   a. July 2023 through April 2024 - Audit Operations Period – 10 Months – During this period it is anticipated the PHPs are working with their auditors to gather the appropriate information and evidence to generate the final report.
   b. May 2024 – June 2024 - Report and Review Period – 2 Months – During this period it is anticipated that the PHP is working with its auditor to review the final findings and document, and provide any additional evidence or other feedback needed to complete the report.
   c. June 30, 2024 – The finalized document is due to the Department.

ii. The cycle outlined above will be repeated for each scheduled submission of the SOC 2 Type II report. In addition, the PIHP shall use the same cycle for their Subcontractors. The PIHP shall collect and review the final reports of all Subcontracts in compliance with the requirements in the Contract. The PIHP shall follow all Department, State, and federal security rules, regulations, policy and statutes and to flow down the relevant contractual requirements to their Subcontractors.

hhhhhh. *Section IV. Scope of Services, M. Innovation Waiver Services for PIHP Members, 3. Tailored Care Management, a. Eligibility for Tailored Management Care* is revised and restated follows:

a. Eligibility for Tailored Care Management
   i. All Members enrolled in the Innovations Waiver are eligible for Tailored Care Management, with the following exceptions for Members participating in services that are duplicative of Tailored Care Management:
      1. Members receiving Assertive Community Treatment (ACT);
      2. Members participating in Care Management for At-Risk Children (CMARC);
      3. Members obtaining care management from the Department's PCCM vendor;
      4. Members participating in the High-Fidelity Wraparound program as described in *Section IV.G.7 Other Care Management Programs*; and
      5. Tailored Care Management shall incorporate all Innovations Waiver care coordination activities, as required in the Innovations Waiver.
   ii. Enrollment in Tailored Care Management
      1. The PIHP shall enroll and disenroll Innovation Waiver Members eligible for Tailored Care Management into Tailored Care Management as required in *Section IV.G.2. Tailored Care Management*.
      2. The PIHP shall auto-enroll new members who obtain an Innovations Waiver slot after PIHP launch into Tailored Care Management if they are not already enrolled in Tailored Care Management. The PIHP shall send new Waiver enrollees information about Tailored Care Management and the option to opt out with the materials informing them of their Waiver slot.
      3. The PIHP must auto-enroll all current Innovations Waiver enrollees in Tailored Care Management.
         i. Innovations Waiver enrollees may opt out of Tailored Care Management.
         ii. Innovations Waiver enrollees who have opted out of Tailored Care Management shall still receive care coordination as described in *Section IV.G.3. Care Coordination and Care Transitions for all Members* and Innovations Waiver care coordination as described in *Section IV.M. Innovation Waiver Services for PIHP Members.*
      4. In cases where a member enrolled in the Innovations Waiver opts out of Tailored Care Management, the PIHP must provide the Innovations Waiver care coordination services as stipulated by the Innovations Waiver.

iii. Tailored Care Management Assignment

1. The PIHP shall ensure that all eligible Members enrolled in the Innovations Waiver have a choice of organization where they obtain Tailored Care Management.
2. The PIHP shall consider the following factors when assigning each Member enrolled in the Innovations Waiver to care management at an AMH+ practice or a CMA, or at the PIHP level:
   i. If the member enrolled in the Innovations Waiver has an existing relationship with an LME/MCO care coordinator who meets the Tailored Care Management qualifications and training requirements as described in *Section IV.B.3. Staff Training* and is employed by the member's PIHP or in the PIHP's network, the PIHP must give the member the option of choosing their previous care coordinator as their Tailored Care Management care manager, to the extent possible.
   ii. The PIHP shall assign members enrolled in the Innovations Waiver and members obtaining 1915(i) services who are engage in Tailored Care Management to Tailored Care Management that complies with federal requirements for conflict-free case management for 1915(c) Waiver enrollees. 42 C.F.R. § 431.301(c)(1)(vi) and 42 C.F.R. § 441.730.(b). The PIHP shall ensure that members do not obtain both 1915(c) Waiver services and Tailored Care Management from employees of the same provider organization that is certified as a CMA.
3. The PIHP shall provide written notification to members regarding requirements for conflict-free case management, including that:
   i. Members are entitled to choice in the organization where they obtain Tailored Care Management;
   ii. Members are entitled to choice in their 1915(c) or 1915(i) service providers; and
   iii. Members cannot obtain both Tailored Care Management and 1915(i) services or both Tailored Care Management and 1915(c) services, as applicable to the member, through the same provider organization .
   iv. The PIHP must submit a draft of this notice to the Department for approval.

iv. Development of Care Plan/Individual Support Plan (ISP for Members Engaged in Tailored Care Management)

1. The PIHP shall ensure that each Care Plan/ISP for Innovations members meets the requirements of *Section IV.G.2 Tailored Care Management* incorporates results of SIS® screening and/or level of care determination tool, unless modified by the Department.

v. Additional Tailored Care Management Requirements for Members Enrolled in the Innovations Waiver

1. For members who were enrolled in the Innovations Waiver prior to PIHP launch and engage in Tailored Care Management:
   i. If the member's ISP annual update is in the first six (6) months of Year 1 of PIHP launch, the PIHP shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment prior to completing the ISP.
   ii. If the member's annual update is in the second half of Year 1 of PIHP launch, the PIHP shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment according to the timeframes described in *Section IV.G.2. Tailored Care Management*. The PIHP shall ensure that the organization providing Tailored Care Management completes the care management comprehensive assessment prior to the annual update, and in subsequent years, aligns the timing of the reassessment with the ISP annual update.
   iii. The ISP developed prior to PIHP launch will continue to serve as the ISP under Tailored Care Management in Year 1 of PIHP operation, until updated.

iv. The PIHP must ensure that the ISP is aligned with Tailored Care Management requirements at the member's next annual update (during the month before the individual's birth month), after a triggering event or at the member's request.
v. Prior to the annual update, the member's care management comprehensive assessment results may be used to amend the ISP if appropriate, but a full update is not required.

2. If the member is enrolled in the Innovations Waiver, when determining required care management contacts, the assigned organization providing Tailored Care Management shall adhere to, whichever is higher in frequency and modality (e.g., number of in-person contacts):
   i. The contact requirements found in the 1915(c) Waiver, or
   ii. The contacts noted in *Section IV.G.2. Tailored Care Management*.
3. For Innovations Waiver enrollees, the PIHP shall ensure that results of the SIS® are shared with the member's care manager in an electronic format to aid completion of the care management comprehensive assessment.

vi. Additional Staffing and Training Requirements for Care Managers Delivering Tailored Care Management to Innovation Waiver members
1. Current Innovations Waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.

vii. Additional Oversight of Tailored Care Management for Innovation Waiver members
1. For Innovations Waiver members engaged in Tailored Care Management, the PIHP must ensure compliance with federal requirements for conflict-free case management for members enrolled in a 1915(c) Waiver as described further in *Section IV.G.2. Tailored Care Management*. 42 C.F.R. § 441.301(c)(1)(vi).

viii. Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver
1. In cases where a member enrolled in the Innovations Waiver opts out of Tailored Care Management, the PIHP must provide the Innovations Waiver care coordination services as stipulated by the Innovations 1915(c) Waiver and in alignment with the requirements of 42 C.F.R. § 438.208(c).
   i. The PIHP shall ensure that Innovations Waiver care coordination services are performed by a care manager meeting the following qualifications:
      a. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area;
      b. Two (2) years of experience working directly with individuals with I/DD; and
      c. Two (2) years of prior Long Term Service and Support (LTSS) and/or Home and Community-Based Services (HCBS) coordination, care delivery monitoring and care management experience.
2. The Department will not make a Tailored Care Management payment to the PIHP for members who opt out of Tailored Care Management, as described in *Section IV.H.4. Provider Payments*.
3. For all members enrolled in the Innovations Waiver, regardless of whether they engage in Tailored Care Management, the PIHP shall ensure that Waiver care coordination includes:
   i. Guiding the development and submission of the ISP, based on assessed need and living arrangements, at least annually:
      a. The PIHP shall ensure that the member's care manager convenes a person-centered planning meeting and completes the ISP. This is done after the member is administered the SIS® and the level of care determination for initial plans of care.
      b. If applicable, the PIHP shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the ISP to the PIHP.

c. The PIHP shall review ISP for Waiver compliance, medical necessity, and the member's health and safety needs.
d. The PIHP shall approve or deny the ISP within standard service authorization periods except for in the case of initial plans which must be received within sixty (60) Calendar Days of level of care determination. In the case where services are needed more immediately, an interim plan of care may be completed so that services may be approved with the full ISP being completed afterwards and within the sixty (60) Calendar Days of level of care determination.
e. The PIHP shall ensure that Waiver services begin within forty-five (45) Calendar Days of ISP approval.
f. The PIHP shall ensure that the member provides a signature (wet or electronic) on the ISP to indicate informed consent, in addition to ensuring that the ISP includes signatures from all individuals and providers responsible for its implementation. As part of the consent process, members must consent to the following:
    (1) By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
    (2) My care manager helped me know what services are available.
    (3) I was informed of a range of providers in my community qualified to provide the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
    (4) The plan includes the services/supports I need.
    (5) I participated in the development of this plan.
    (6) I understand that my care manager will be coordinating my care with the [LME/MCO] network providers listed in this plan.
    (7) I understand that all services under the Innovations Waiver, including Residential Supports and Supported living, should be requested to the full extent of the individual's level of medical necessity; regardless of the individual's budgeting category.
    (8) I understand that services may be authorized in excess of the Individualized Budget.

ii. Monitoring and contact requirements found in the 1915(c) Waiver.
iii. Explaining the individual budgeting tool, the service authorization process and the mechanisms available to the member/legally responsible person (LRP) to modify their budget.
iv. Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the ISP, including providing a list of available providers and arranging provider interviews.
v. Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal.
vi. Maintaining close contact with the member/LRP (if applicable), providers and other members of the ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
vii. Informing the member/LRP of the option to participate in individual-directed/family-directed supports.
viii. Assisting in the appointment of the representative for self-direction, as needed.
ix. Assessing the employer of record, managing employer and representative, if applicable, to determine the areas of support needed to self-direct services.

x. Promoting the delivery of services and supports in the most clinically appropriate, integrated setting.
xi. Completing annual reassessment of the member's level of care.
xii. Ensuring that the member/LRP completes the Freedom of Choice statement annually.
xiii. Completing the NC Innovations Risk/Support Needs Assessment / or other approved assessment, prior to the development of the ISP and updating at least annually or as significant changes occur with the member.
xiv. Providing timely notification to PIHP utilization management of updates to the level of care determination and timely processing of updates to the ISP.
xv. Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support Plan.
xvi. Monitoring of service delivery to verify that:
    a. At least one (1) service is utilized monthly, per Innovations Waiver requirements, with the exception of children under the age of twenty-one (21) with a diagnosis of autism spectrum disorder (ASD) who are actively engaged in a research-based intervention for the treatment of ASD.
    b. Services are furnished in accordance with the ISP.
    c. Member is offered a choice of Waiver service providers.
    d. Member has access to services and services meet the member's needs.
    e. Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-Waiver service needs (medical care) are addressed and documented as appropriate.
    f. Services utilized do not exceed authorization.
    g. Member is satisfied with the services being rendered.
    h. Services are compliant with HCBS final rule as applicable.

4. The PIHP shall notify the member's provider and AMH+ practice or CMA (if applicable) of authorization decisions.

ix. In-Reach and Transition from Institutional Settings
1. For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.

x. In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State
1. The PIHP shall be responsible for providing transition services for Members residing in ICF-IIDs not operated by the state. Transition activities for Members residing in ICF-IIDs not operated by the state must include, at a minimum:
    i. For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.

xi. Care Management and Care Coordination Policy
1. The PIHP shall submit its policies and procedures for Innovation Waiver members part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*). As long as the Care Management and Care Coordination Policy clearly states that it apply to the PIHP, the Care Management and Care Coordination Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan Contract.

4. Modifications to Section V. Contract Performance

Specific subsections are modified as stated herein.

a. *Section V. Contract Performance, A. Contract Compliance and Performance, 3. Risk Level Assessment, a.* is revised and restated as follows:

a. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or of applicable law (each considered a "Violation"), the Department shall assign the Violation into one of four risk levels:
   i. Level 1: Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care or services; and/or jeopardize the integrity of Medicaid Services.
   ii. Level 2: Action(s) or inaction(s) that jeopardize the integrity of Medicaid Services but does not necessarily jeopardize Members' health, safety, and welfare or reduces access to care.
   iii. Level 3: Action(s) or inaction(s) that diminish the effective oversight and administration of Medicaid Services.
   iv. Level 4: Action(s) or inaction(s) that inhibit the efficient operation of Medicaid Services.

b. *Section V. Contract Performance, F. Payment of Liquidated Damages and other Monetary Sanctions, 1.* is revised and restated as follows:

1. If the PIHP elects not to dispute the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within thirty (30) Calendar Days of the date of the written Notice of Deficiency assessing the liquidated damages or other monetary sanctions.

c. *Section V. Contract Performance, G. Dispute Resolution for Contract Performance, 2.* is revised and restated as follows:

2. The PIHP shall have the right to dispute certain contract performance actions by the Department, including the imposition of CMPs, intermediate sanctions, liquidated damages, or termination, through the dispute resolution process, except that the PIHP shall not have the right to dispute the Department's decision to require the PIHP to perform a remedial action.

d. *Section V. Contract Performance, G. Dispute Resolution for Contract Performance, 3. Dispute Resolution Procedures, a.* is revised and restated as follows:

3. To initiate a dispute, the PIHP shall submit a written request for a dispute resolution within thirty (30) Calendar Days of the date of the Notice of Deficiency imposing the Department's intended action. The Department may extend the PIHP's deadline to request dispute resolution for good cause if the PIHP requests an extension within ten (10) Calendar Days of the date on the written notice.

5. Modifications to Section VI. Contract Attachments

Specific subsections are modified as stated herein.

a. *Section VI. Attachment B. Approved Behavioral Health In Lieu of Services for Medicaid* is revised and restated as *Section VI. First Revised and Restated Attachment B. Reserved*.

b. *Section VI. Attachment C. Contractual Deliverable Schedule* is revised and restated as *Section VI. First Revised and Restated Attachment C. Contractual Deliverable Schedule* and attached to this Amendment.

c. *Section VI. Attachment D. PIHP Quality Metrics* is revised and restated i as *Section VI. First Revised and Restated Attachment D. PIHP Quality Metrics* and attached to this Amendment.

d. *Section VI. Attachment E. PIHP Network Adequacy Standards* is revised and restated as *Section VI. First Revised and Restated Attachment E. PIHP Network Adequacy Standards* and attached to this Amendment.

e. *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts* is revised and restated as *Section VI. First Revised and Restated Attachment F. Required Standard Provisions for PIHP and Provider Contracts s* and attached to this Amendment.

f. *Section VI. Attachment G. Addendum for Indian Health Care Providers* is revised and restated as *Section VI. First Revised and Restated Attachment G. Addendum for Indian Health Care Providers* and attached to this Amendment.

g. *Section VI. Attachment H. Provider Appeals* is revised and restated as *Section VI. First Revised and Restated Attachment H. Provider Appeals* and attached to this Amendment.

h. *Section VI. Attachment I. Reporting Requirements* is revised and restated as *Section VI. First Revised and Restated Attachment I. Reporting Requirements* and attached to this Amendment.

i. *Section VI. Attachment K. Managed Care Terminology Provided to the PIHP for Use with Members Pursuant to 42 C.F.R. § 438.10* is revised and restated as *Section VI. First Revised and Restated Attachment K. Managed Care Terminology Provided to the PIHP for Use with Members Pursuant to 42 C.F.R. § 438.10* and attached to this Amendment.

j. *Section VI. Attachment L. Policies, 2. AMH+ Practice and CMA Certification Policy* is revised and restated as *Section VI. Attachment L. Policies, 2. First Revised and Restated AMH+ Practice and CMA Certification Policy* and attached to this Amendment.

k. *Section VI. Attachment L. Policies, 3. Uniform Credentialing and Re-credentialing Policy for Medicaid* is revised and restated as *Section VI. Attachment L. Policies, 3. First Revised and Restated Uniform Credentialing and Re-credentialing Policy for Medicaid* and attached to this Amendment.

l. *Section VI. Attachment L. Policies, 4. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards* is revised and restated as *Section VI. Attachment L. Policies, 4. First Revised and Restated Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards* and attached to this Amendment.

m. *Section VI. Attachment L. Policies* is revised to add *Section VI. Attachment L. Policies, 6. COVID-19 Public Health Emergency Managed Care Policy* which is attached to this Amendment.

n. *Section VI. Attachment L. Policies* is revised to add *Section VI. Attachment L. Policies, 7. Approved <PIHP NAME> In Lieu of Services* which is attached to this Amendment.

o. *Section VI. Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages* is revised and restated as *Section VI. First Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages* and attached to this Amendment.

6. **Effective Date:** This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

7. **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

PIHP Name

_____ Date: _____
PIHP Authorized Signature

Section VI. First Revised and Restated Attachment C. Contractual Deliverable Schedule

The following represents the current *anticipated dates* for Contractual Deliverables. The Department may make adjustments after Contract Execution but in no event will Contractual Deliverables be due earlier than provided for below. For any deliverable which is indicated below as leveraged from the BH I/DD Tailored Plan contract, the PIHP will still be required to submit through the standard process. This column indicates a reduced administrative burden on the PIHP and the Contractual Deliverable may closely mirror the submission for the BH I/DD Tailored Plan.

- If the *Leverage Tailored Plan Deliverable* column of the table below is marked "No", then the PIHP will be required to submit a completely new deliverable specific to the requirements of the PIHP contract.
- If the *Leverage Tailored Plan Deliverable* column of the table below is marked "Yes", then the PIHP may use the same deliverable submitted for the BH/IDD Tailored Plan deliverable submission as the baseline document, provided that modifications are made to incorporate any variations in PIHP program requirements (where applicable).

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
1.	Additional Special Terms with IHCP	Tailored Plan	The date the PIHP shall submit the additional special terms with Indian Health Care Providers.	Yes	Contract Execution + one hundred eighty (180) days
2.	Behavioral Health Crisis Line Script	Benefits	The date all service line scripts, including Member Service Line and Behavioral Health Crisis Line scripts, shall be made available to the Department.	Yes	Ninety (90) days after launch
3.	Business Continuity Plan	Compliance	The date PIHP Business Continuity Plan shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
4.	Call Center Services Line Policy	Call Center	The date the Call Center and Service Line Policy shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
5.	Care Management and Care Coordination Policy	Quality & Pop Health	The date the PIHP shall submit the Care Management and Care Coordination Policy related to Care Management and Care Coordination protections to the Department.	Yes	Contract Effective Date + sixty (60) days
6.	Claims Payment, Review, and Program Integrity Process	Compliance	The date that a PIHP shall develop, maintain, and operate a claims payment, review and program integrity process which minimizes incorrect claim payments and inappropriate claim denials by.	Yes	Contract Execution + one hundred eighty (180) days
7.	Clinical Coverage Policy Attestation	Benefits	The PIHP shall submit a signed attestation to confirm compliance with UM and Clinical Coverage requirements.	Yes	March 31, 2023
8.	Compliance Plan	Compliance	The PIHP shall submit a compliance plan to the department.	Yes	Contract Execution + one hundred eighty (180) days

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
9.	Compliance Program Report	Compliance	The date for the annual report monitoring and auditing work plan(s) for the upcoming year to be submitted.	Yes	Contract Execution + one hundred eighty (180) days
10.	Conflict of Interest Policy	Compliance	The date the PIHP will adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices.	Yes	Contract Execution + one hundred eighty (180) days
11.	Deficit Reduction Act Policies and Procedures	Compliance	The date the Deficit Reduction Act (DRA) Reporting for Medicaid shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
12.	Disclosure of Conflict of Interest	Tailored Plan	The PIHP shall disclose any known conflicts of interest, or perceived conflicts of interest, at the time they arise.	Yes	Ad-Hoc[2]
13.	Disclosure of Ownership Interest	Tailored Plan	The date the PIHP shall disclose the information on individuals or corporations with an ownership or control interest.	Yes	Upon Effective date of the Contract
14.	Encounter Implementation Approach	Finance	The date the PIHP shall provide the Encounter Implementation Approach to the Department.	Yes	Contract Execution + thirty (30) days
15.	EPSDT Policy	Benefits	The date the PIHP shall submit an EPSDT Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
16.	Establishment of PIHP Call Center(s) in NC	Tailored Plan	The date the PIHP shall begin implementing call center(s) and staff in North Carolina if not already in place and submit to the Department.	Yes	Contract Execution + ninety (90) days
17.	Establishment of PIHP Office in NC	Tailored Plan	The date the PIHP shall begin implementing Medicaid Direct staff in North Carolina if not already in place and submit to the Department.	Yes	Contract Execution + sixty (60) days
18.	Exception to Network Adequacy Standards	Tailored Plan	The PIHP shall submit their request for an Exception to Network Adequacy Standards forty-five (45) Calendar Days before an exception is set to expire	Yes	Ad-Hoc[3]
19.	Fraud Prevention Plan	Compliance	The date the PIHP shall submit their Fraud Prevention Plan to the Department.	Yes	Contract Execution + one hundred eighty (180) days
20.	Good Faith Provider Contracting Policy	Tailored Plan	The date the PIHP shall develop and submit the Good Faith Provider Contracting Policy that includes a description of how the PIHP will conclude that a "good faith"	Yes	Contract Execution + one hundred eighty (180) days

[2] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe.*

[3] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe.*

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
			contracting effort has been made and/or refused.		
21.	Identification of Additional Resources for Implementation Team	Tailored Plan	The date the PIHP's must identify any additional resources needed to support the implementation activities.	Yes	Contract Execution+ thirty (30) days
22.	Implementation Plan	Tailored Plan	The date PIHP's Implementation Plan Draft must be submitted to the Department.	Yes	Contract Execution + thirty (30) days
23.	In Lieu of Services Request Form	Benefits	The date the PIHP shall submit the ILOS form to the Department.	No	Ad-Hoc[4]
24.	In-Reach and Transition Policy	Quality & Pop Health	The date the PIHP submits the In-Reach and Transition Policy to the Department.	Yes	Contract Execution + ninety (90) days
25.	Key Personnel Matrix	Tailored Plan	The date the PIHP shall submit the Key Personnel Matrix to the Department.	Yes	Contract Execution + one hundred eighty (180) days
26.	Key Personnel Resume and Qualifications	Tailored Plan	The date the PIHP shall submit the Key Personnel resumes and qualifications to the Department.	Yes	Contract Execution + one hundred eighty (180) days
27.	Community Services Crisis Plan	Quality & Pop Health	The date the PIHP shall submit the Community Services Crisis Plans to the Department.	Yes	Contract Execution + one hundred eighty (180) days
28.	Local Community Collaboration and Engagement Strategy	Communications and Stakeholder Engagement	The date the PIHP shall submit the Local Community Collaboratives Strategy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
29.	Locum Tenens Policy	Tailored Plan	The date the PIHP shall submit the Locum Tenens Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
30.	Marketing Materials	Communications and Stakeholder Engagement	Marketing Materials should be submitted to the Department for approval 8 weeks prior to use.	Yes	AdHoc[5]
31.	Marketing Plan	Communications and Stakeholder Engagement	The date the PIHP shall submit their Marketing Plan to the Department.	Yes	July 1, 2023
32.	Member Educational Approach	Member	The date the PIHP submits its planned member education efforts to the Department.	Yes	July 1, 2023
33.	Member Educational Materials	Member	The date all written communications, call center scripts, websites or other communications directed to Members or potential Members, shall be sent to the Department for approval.	Yes	July 1, 2023

[4] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe.*

[5] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe.*

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
34.	Member Engagement and Marketing Plan for Historically Marginalized Populations	Communications and Stakeholder Engagement	The date the PIHP submits the Member Engagement and Marketing Plan for Historically Marginalized Populations to the Department.	Yes	January 6, 2023
35.	Member Enrollment and Disenrollment Policy	Member	The date the PIHP shall submit the Member Enrollment and Disenrollment Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
36.	Member Grievances and Appeals Policies	Member	The date the PIHP shall submit the PIHP Member Grievances and Appeals Policies to the Department.	Yes	Contract Execution + one hundred eighty (180) days
37.	Member Handbook	Member	The date the PIHP will submit the Member Handbook to the Department.	No	Contract Execution + ninety (90) days
38.	Member Incentive Program	Quality & Pop Health	The date the Member Incentive Program shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
39.	Member Mailing Policy	Member	The date the Member Mailing Policy shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
40.	Member Rights and Responsibilities Policy	Member	The date the PIHP shall submit the Member Rights and Responsibilities Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
41.	Member Service Line Script	Member	The date the listing of topics which scripts will address to the Department for approval.	Yes	Ninety (90) days after launch
42.	Member Welcome Packet	Member	The date the PIHP submits the Member Welcome Packet to the Department.	No	July 1, 2023
43.	Network Access Plan	Tailored Plan	The date the PIHP shall provide the Network Access Plan to the Department.	Yes	July 1, 2023
44.	Non-Discrimination Policy	Compliance	The date the PIHP will submit the Non-Discrimination Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
45.	Operating Plan	Tailored Plan	The date the PIHP's Operating Plan shall be submitted to the Department	Yes	June 30th Every Year
46.	Performance Improvement Projects	Quality & Pop Health	The date the PIHP shall submit the PIPs to the Department.	Yes	Contract Execution + Sixty (60) days
47.	Plan for Protection Against Insolvency	Finance	The date the PIHP shall submit a plan for protection against insolvency to the Department.	Yes	Contract Execution + one hundred eighty (180) days
48.	Provider Contract Templates	Tailored Plan	The date the PIHP shall provide Provider Contract Templates to the Department.	No	Contract Execution + thirty (30) days
49.	Provider Directory	Provider	The PIHP shall submit the Provider Directory to the Department.	Yes	Contract Execution + one hundred eighty (180) days

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
50.	Provider Grievances and Appeals Policies	Provider	The date the PIHP shall submit the PIHP Provider Grievances and Appeals Policies.	Yes	Contract Execution + Sixty (60) days
51.	Provider Hardship Payment policy	Finance	The PIHP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval.	Yes	Contract Execution + thirty (30) days
52.	Provider Manual	Provider	The date the PIHP shall provide the Provider Manual to the Department.	Yes	Contract Execution + ninety (90) days
53.	Provider Payment Monitoring and Audit Policy	Compliance	The PIHP shall submit policies and procedures to perform monitoring and auditing of provider payments to the Department.	Yes	Contract + one hundred eighty (180) days
54.	Provider Recruitment Materials	Provider	The PIHP shall submit recruitment materials to the Department for review at least ninety (90) Calendar Days before the proposed use of the material.	Yes	Ad-Hoc[6]
55.	Provider Support Service Line Script	Provider	The date the PIHP will submit to the Department, for approval, a listing of topics which scripts will address.	Yes	Ninety (90) days after launch
56.	Provider Training Materials	Provider	The PIHP shall provide education, specific to PIHP requirements, policies, including the Department's Medicaid Direct BH/I/DD Billing Guide, and procedures, training and technical assistance on all PIHP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.	Yes	Contract Execution + one hundred eighty (180) days
57.	Provider Training Plan	Provider	The date the PIHP shall provide the Provider Training Plan to the Department.	Yes	Contract Execution + one hundred eighty (180) days
58.	Provider Transition of Care Policy	Quality & Pop Health	The date the PIHP shall submit the Medicaid Provider Transition of Care Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
59.	Provider Welcome Packet	Provider	The date the PIHP shall submit a Provider Welcome Packet to the Department.	Yes	Contract Execution + one hundred eighty (180) days
60.	Quality Management and Improvement Program (QMIP)	Quality & Pop Health	The date the PIHP shall submit a Quality Management and Improvement Program to the Department.	Yes	Contract Execution + Sixty (60) days
61.	Reimbursement Policy	Finance	The PIHP shall submit the Reimbursement Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
62.	Reinsurance Arrangement	Finance	The PIHP shall submit their Service Line Phone Numbers to the Department.	Yes	Contract Execution + one hundred eighty (180) days

[6] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe.*

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
63.	Security Compliance Plan	Technology	The date the PIHP shall provide the Security Compliance Plan to the Department.	Yes	Contract Execution + thirty (30) days
64.	Service Line Phone Numbers	Call Center	The date the PIHP must have its service line phone number acquired and operationalized.	Yes	Contract Execution + one hundred eighty (180) days
65.	Soc 2 Type II Assessment	Technology	The date the PIHP shall provide the SOC 2 Type II Assessment to the Department.	Yes	June 30, 2024
66.	Staff Training and Evaluation Program	Staff Training	The PIHP shall submit their training and evaluation program to the Department.	Yes	Contract Execution + one hundred eighty (180) days
67.	Staff Training Materials	Staff Training	The date the PIHP shall submit their Staff Training Materials to the Department.	Yes	Contract Execution + one hundred eighty (180) days
68.	Subcontractor Identification	Tailored Plan	The PIHP shall submit an updated subcontractor identification form (Attachment O) sixty (60) Calendar Days prior to the start of services by a Subcontractor not previously approved by the Department.	Yes	Ad-Hoc[7]
69.	System Interface Design	Technology	The date the PIHP shall provide the System Interface Design to the Department.	Yes	Contract Execution + thirty (30) days
70.	System of Care Policy	Quality & Pop Health	The date the PIHP shall submit their System of Care Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
71.	System Test Plan	Technology	The date the PIHP shall provide the System Test Plan to the Department.	Yes	July 31, 2022
72.	Telehealth and Virtual Patient Communications Policy	Benefits	The date the PIHP shall submit their Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
73.	Third Party Administrator License (as applicable)	Tailored Plan	The date the PIHP shall submit their Third-Party Administrator's license if applicable.	Yes	Contract Execution + one hundred eighty (180) days
74.	Third-Party Liability Policy	Finance	The date the PIHP shall submit their Third-Party Liability Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
75.	Transition of Care Policy	Quality & Pop Health	The date the PIHP shall submit the Medicaid Transition of Care Policy to the Department.	Yes	Contract Execution + one hundred fifty (150) days

[7] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe.*

Section VI. First Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
76.	Tribal Engagement Strategy (as applicable)	Member	The date the PIHP's Tribal Engagement Strategy Medicaid shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
77.	Utilization Management Policy	Benefits	The date the PIHP shall submit their UM Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
78.	Value-Added Services Request Form	Benefits	The PIHP shall submit to the Department the Value-Added Services Request form for approval.	No	Contract Execution + one hundred eighty (180) days
79.	VBP Assessment	Finance	The date the PIHP's first retrospective VBP Assessment shall be submitted to the Department.	Yes	Contract Year 1 + ninety (90) days
80.	VBP Strategy	Finance	The date the PIHP shall submit the prospective VBP Strategy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
81.	Vendor Readiness Assessment Report	Technology	The date the PIHP shall provide the VRAR to the Department.	Yes	Contract Execution + thirty (30) days
82.	Website Content	Member	The date the PIHP shall submit Website Content to the Department.	Yes	Contract Execution + one hundred eighty (180) days
83.	Whistleblower Policy	Compliance	The date the PIHP shall submit the Whistleblower Policy related to whistleblower protections to the Department.	Yes	Contract Execution + one hundred eighty (180) days

Section VI. First Revised and Restated Attachment D. PIHP Quality Metrics

The PIHP will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be provided no later than six (6) months prior to PIHP launch.

Updates to PIHP Quality Metrics

a. The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website as necessary, to align with the annual January update.
b. The PIHP shall begin to track the updated measures when posted annually in January.
c. The PIHP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with First Revised and Restated Section VII. Attachment D. (e.g., for updates to the quality metrics posted in January 2023, the PIHP would report the results in June 2024).

The PIHP will also be required to report the Innovations waiver measures listed, which can be included in reporting for the BH/IDD Tailored Plan. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with PIHPs around these performance measures.

The PIHP will also be required to report the 1915(i) measures listed *in Section VI. First Revised and Restated Attachment D. Table 4: 1915 (i) Performance Measurers*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with the PIHP around these performance measures.

Section VI. First Revised and Restated Attachment D. Table 1: Survey Measures and General Measures: Pediatric					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
4.	0108	Follow-up for Children Prescribed ADHD Medication	NCQA	Annually Calendar Year	June 1
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1
9.	2801	Use of Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1
10	N/A	Total Eligible Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	NC DHHS	Annually Calendar Year	June 1

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Section VI. First Revised and Restated Attachment D. Table 2: Survey Measures and General Measures: Adult					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA	Annually Calendar Year	June 1
6.	3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC	Annually Calendar Year	June 1
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	Annually Calendar Year	June 1
10.	0576	Follow-up After Hospitalization for Mental Illness	NCQA	Annually Calendar Year	June 1
16.	NA	Rate of Screening for Unmet Resource Needs	NC DHHS	Annually Calendar Year	June 1

Section VI. First Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
5.	Proportion of Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1

Section VI. First Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Innovations waiver providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
14.	Percentage of beneficiaries reporting that their ISP has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of ISPs that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
16.	Proportion of ISPs in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of individuals whose annual ISP was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
18.	Proportion of individuals for whom an annual ISP took place.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11

Section VI. First Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
19.	Number and percentage of waiver participants whose ISPs were revised, as applicable, by the Care Coordinator to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the ISP.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 a. November 1
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percentage of Innovations waiver beneficiary deaths where required PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. First Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
26.	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
27.	Percentage of Innovations waiver beneficiaries who received appropriate medication.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Percentage of medication errors resulting in medical treatment for Innovations wavier beneficiaries.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
30.	Percentage of PIHP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death.	NC DHHS	Annually July 1 –June 30	November 1

Section VI. First Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
32.	Number and percentage of level 2 or 3 incidents where required PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
33.	Percentage of level 2 and 3 incidents reported within required timeframes.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields.	NC DHHS	Annually Fiscal Year	November 1
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. First Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
37.	The proportion of claims paid by the PIHP for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
38.	The consistency of NC Innovations capitated rates (The proportion of the PIHP Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM).	NC DHHS	Annually Fiscal Year	November 1
39.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver (ages 3 and older) who received at least one waiver service who also received a primary care or preventative health service.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
40.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
41.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
42.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. First Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new PIHP members who have an independent evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number of PIHP members who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
3.	Number of PIHP members with SMI/SED who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
4.	Number of PIHP members with SUD who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
5.	Number of PIHP members with I/DD who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
6.	Number of PIHP members with TBI who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
7.	Number of PIHP members on the Innovations waitlist who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of independent re-evaluations completed at least annually for PIHP members using 1915(i) services.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
9.	Proportion of new independent evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of independent evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) services.	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of 1915(i) service providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of non-certified 1915(i) service providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
18.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
19.	Percentage of beneficiaries reporting that their Care Plan/ISP has the services that they need.	NC DHHS	Annually Fiscal Year	November 1

Section VI. First Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
20.	Proportion of Care Plan/ISPs that address identified health and safety risk factors.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
21.	Proportion of Care Plans/ISPs in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of individuals whose annual Care Plan/ISP was revised or updated.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
23.	Proportion of individuals for whom an annual Care Plan/ISP took place.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
24.	Number and percentage of PIHP members using 1915(i) services whose Care Plans/ISPs were revised, as applicable, by the Care Manager to address their changing needs.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
25.	Proportion of beneficiaries who are using 1915(i) services in the type, scope, amount, and frequency as specified in the Care Plan/ISP.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1
27.	Proportion of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
28.	Proportion of PIHP members using 1915(i) services reporting their Care Manager helps them to know what 1915(i) services are available.	NC DHHS	Annually Fiscal Year	November 1
29.	Proportion of PIHP members using 1915(i) services reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
30.	Number and percentage of beneficiary deaths of PIHP members using 1915(i) services where required BH I/DD Tailored Plan follow-up interventions were completed as required.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VI. First Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
31.	Number and percent of actions taken to protect the beneficiary using 1915(i) services, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
32.	Percentage of PIHP members using 1915(i) services who received appropriate medication.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
33.	Percentage of medication errors resulting in medical treatment for PIHP members using 1915(i) services.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
34.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Quarterly July 1 –September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	Percentage of PIHP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death.	NC DHHS	Annually July 1 – June 30	November 1
36.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November
37.	Number and percentage of level 2 or 3 incidents where required PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly July 1 –September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VI. First Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
38.	Percentage of level 2 and 3 incidents reported within required timeframes.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
39.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields.	NC DHHS	Annually Fiscal Year	November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
42.	The proportion of claims paid by the BH I/DD Tailored Plan for 1915(i) services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
43.	The percentage of continuously enrolled PIHP members using 1915(i) services (ages 3 and older) who also received a primary care or preventative health service.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
44.	The percentage of continuously enrolled PIHP members using 1915(i) services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled PIHP members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VI. First Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
47.	The percentage of continuously enrolled PIHP members using 1915(i) services ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	 February 1 May 1 August 1 November 1

Section VI. First Revised and Restated Attachment E. PIHP Network Adequacy Standards

At a minimum, the PIHP network shall consist of hospitals, physicians, advanced practice nurses, SUD and mental health treatment providers, TBI and I/DD providers, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section IV.H.1. Provider Network.*
For the purposes of this attachment and the PIHP Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties which will be covered by the applicable PIHP." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

More background information is available at the following link, accurate as of the date of execution of this Contract: http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all Members have timely access to all covered health care services, PIHP shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a Member who is 18 years of age, or older and pediatric/adolescent (child/children) services are those provided to a Member who is less than 18 years of age.

The PIHP is required to use the definitions of service categories for BH time/distance standards found in Distance Standards for BH service types in this attachment.

Section VI. First Revised and Restated Attachment E. Table 1: PIHP Time/Distance Standards

Reference Number	Service Type	Urban Standard	Rural Standard
1	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • *Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD)*: Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • *Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
2	Location-Based Services	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • *Child and Adolescent Day Treatment Services:* Not subject to standard	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members

Section VI. First Revised and Restated Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
			• *Child and Adolescent Day Treatment Services:* Not subject to standard
3	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: ○ 2+ facilities within each PIHP Region, OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* ≥ 1 provider within each PIHP Region • Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification*:* ≥ 2 provider within each PIHP Region • *Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification), Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal (social setting detoxification):* ≥ 1 provider of each crisis service within each PIHP Region • *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	
4	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP region	
5	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
6	Community/ Mobile Services	≥ 2 providers of community/mobile services within each PIHP Region. Each county in PIHP Region must have access to ≥ 1 provider that is accepting new patients.	
7	Reserved.		
8	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per PIHP Region • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment)*:* Access to ≥ 1 licensed provider per PIHP Region *(refer to 10A NCAC 27G.3400)* • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): ○ *Adult:* Access to ≥ 1 licensed provider per PIHP Region (refer to licensure requirements to be determined by the Department: Not subject to standard until 90 calendar days after licensure requirements are established) ○ *Adolescent:* Contract with all designated CASPs statewide ○ *Women & Children:* Contract with all designated CASPs ~~s~~tatewide • Clinically Managed Population-Specific High Intensity Residential Program: contract with all designated CASPs • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house: ○ *Adult:* Access to ≥1 male and ≥1 female program per PIHP Region (Refer to 10A NCAC 27G .5600)[8] ○ *Adolescent:* Access to ≥1 program per PIHP Region (refer to 10A NCAC 27G.5600) • *Psychiatric Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard	

[8] PIHPs must also ensure that gender non-conforming Members have access to substance abuse halfway house services.

Section VI. First Revised and Restated Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
9	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living:* ≥ 2 providers of each Innovations waiver service within each PIHP Region • *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:* ≥ 1 provider of each Innovations waiver service within each PIHP Region • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification*: Not subject to standard	
10	1915(i) Services	• *Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD):* ≥ 2 providers of each 1915(i) service within each PIHP Region • *In-Home Respite:* ≥ 2 providers within 45 minutes of the member's residence. • *Community Transition:* Not subject to standard	
11	All State Plan LTSS (except nursing facilities and 1915(i) services)*	• ≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county	
12	Employment and Housing Services	• *Individual Placement and Supports (IPS) – Supported Employment (Adult MH):* Eligible individuals shall have the choice of at least two (2) provider agencies within each PIHP Region. Each county in PIHP Region must have access to ≥1 provider that is accepting new patients	

Section VI. First Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Diagnostic Assessment • Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (BH I/DD)	• Psychosocial Rehabilitation • Substance Use Comprehensive Outpatient Treatment • Substance Use Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification) • Ambulatory withdrawal management with extended on-site monitoring • Clinically managed residential withdrawal services (social setting detoxification) • Medically monitored inpatient withdrawal services (Non-hospital medical detoxification) (adult)

Section VI. First Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
		• Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Medically managed intensive inpatient withdrawal management (Acute care hospitals with adult inpatient substance use beds) • Medically managed intensive inpatient services (Acute care hospitals with adult inpatient substance use beds) *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Medically managed intensive inpatient services (Acute care hospitals with adolescent inpatient substance use beds) • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial Hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment facility services • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment): • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): • Clinically Managed Population-Specific High Intensity Residential Program • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house): • Psychiatric Residential Treatment Facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
7.	Community/Mobile Services	• Assertive Community Treatment (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports • Diagnostic Assessment
8.	1915(i) HCBS	• Supported Employment • Individual Support • Respite • Community Living and Support • Community Transition
9.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite

Section VI. First Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
		• Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications
10.	Reserved.	
11.	Employment and Housing Services	• Individual Placement and Support-Supported Employment (Adult MH)

The PIHP is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service.

Section VI. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Behavioral Health and I/DD Services			
1	Mobile Crisis Management Services	Refer to *Section VI. Attachment M.4 BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within two (2) hours
2	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Emergency Services available immediately{available twenty-four (24) hours a day, 7 days a week.
3	Emergency Services for Mental Health	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Immediately available twenty-four (24) hours a day, 7 days a week. }
4	Emergency Services for SUD	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Immediately available twenty-four (24) hours a day, 7 days a week.
5	Urgent Care Services for Mental Health	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within twenty-four (24) hours

Section VI. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
6	Urgent Care Services for SUD	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within twenty-four (24) hours
7	Routine Services for Mental Health	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within fourteen (14) calendar days
8	Routine Services for SUDs	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within forty-eight (48) hours

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Section VI. First Revised and Restated Attachment F. Required Standard Provisions for PIHP and Provider Contract

The PIHP shall develop and implement contracts with providers to meet the requirements of the Contract or have the option to amend BH I/DD Tailored Plan contracts with providers to add Medicaid Direct requirements as an Addendum or Attachment. The PIHP provider contracts shall, at a minimum, comply with the terms of the Contract, state and federal law, and include required standard contracts clauses.

a. Contracts between the PIHP and providers, must at a minimum, include provisions addressing the following:

i. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.

ii. Definitions: The contract must define those technical managed care terms used in the provider 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.

1. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PIHP utilizes the definition as found in Section II.A. of the PIHP Contract or include the definition verbatim from that section.

iii. Contract Term: The contract term shall not exceed the term of the PIHP Contract with the State, but may include the option to extend the contract's term if the PIHP Contract with the state includes an extension option.

iv. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PIHP shall specifically include a provision permitting the PIHP 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, or serious quality of care concerns by the PIHP or the Division, or upon termination of the PIHP contract by the State. PIHP also shall specifically include a provision permitting the PIHP to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the PIHP or the Division. The contract must also require the provider to notify the PIHP of members with scheduled appointments upon termination. The contract may include a no-cause termination clause.

v. Survival: The contract must identify those obligations that continue after termination of the provider contract and

1. In the case of the PIHP'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 PIHP 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.

vi. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PIHP's Network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and the timeframe within in which the provider must notify the PIHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:

1. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
2. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
    a. During the provider credentialing transition period, no less frequently than every five (5) years.
    b. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

vii. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PIHP, and at the provider's sole cost, and to notify the PIHP of subsequent changes in status of professional liability insurance on a timely basis.

viii. Member Billing: The contract must address the following:

1. That the provider shall not bill any 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 PIHP may not cover or continue to cover specific services and the member requests to receive the service; and
2. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

ix. 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 PIHP's standards for provider accessibility. The contract must address how the provider will:

1. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;
2. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
3. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider's competency to meet individual referral needs will be negotiated between the PIHP and the provider.

x. Eligibility Verification: The contract must address the PIHP's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the PIHP, before rendering health care services.

xi. 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:

1. Maintain confidentiality of member medical records and personal information and other health records as required by law;
2. Maintain adequate medical and other health records according to industry and PIHP standards; and
3. Make copies of such records available to the PIHP and the Department in conjunction with its regulation of the PIHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

xii. 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.

xiii. Provider Network: The PIHP shall require network providers of services provided under Outpatient Commitment to a member to notify the PIHP of the Outpatient Commitment order upon receipt.

xiv. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment or bias that does not affirm their orientation.

xv. 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. Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the PIHP's web-based billing process.

xvi. Data to the Provider: The contract must address the PIHP's obligations to provide data and information to the provider, such as:

1. Performance feedback reports or information to the provider if compensation is related to efficiency criteria.
2. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
3. Notification of changes in these requirements shall also be provided by the PIHP, allowing providers time to comply with such changes.

xvii. Utilization Management (UM): The contract must address the provider's obligations to comply with the PIHP's UM 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.

xviii. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.

xix. Provider Directory: The provider's authorization and the PIHP's obligation to include the name of the provider or the provider group in the provider directory distributed to members.

xx. Dispute Resolution: Any process to be followed to resolve contractual differences between the PIHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section IV.H.4. Provider Grievances and Appeals.*

xxi. Assignment: Provisions on assignment of the contract must include that:

1. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PIHP.
2. The PIHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.

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

xxiii. Interpreting and Translation Services: The contract must have provisions that indicate:

1. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
2. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.

3. The provider shall report to the PIHP, in a format and frequency to be determined by the PIHP, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

xxiv. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.

xxv. Miscellaneous Provisions - The contract shall include provisions which address the following:

1. If the PIHP determines that services, supplies, or other items are covered and Medically Necessary, the PIHP shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

2. When the PIHP offers to contract with a provider, the PIHP shall make available its schedule of fees, if any associated with the top 30 services or procedures most commonly billed by the class of provider, with the exception of Value-Based Fees, which would not be included until Contract Year 2.

3. The contract shall include the following definitions:
   a. "Amendment" – Any change to the terms of a contract, including terms incorporated by reference, that modifies the fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order or by the PIHP Contract is not an amendment.
   b. "Contract" – A written agreement between an insurer and a Medicaid-enrolled provider for the provision of health care services by the provider on an in-network basis.
   c. "Health care provider" – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

4. Notice contact provisions - The contract shall address the following:
   a. All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.
   b. Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five (5) business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider.

5. Contract Amendments - The contract shall address the following:

a. PIHP shall send any proposed contract amendment to the notice contact of a health care provider. The proposed amendment shall be dated, labeled "Amendment," signed by the PIHP, and include an effective date for the proposed amendment.
b. A health care provider receiving a proposed amendment shall be given at least sixty (60) days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within sixty (60) days.
c. If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the PIHP shall be entitled to terminate the contract upon sixty (60) days written notice to the health care provider.
d. A health care provider and the PIHP may negotiate contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.

6. Policies and Procedures: The contract shall address the following:
   a. PIHP's policies and procedures applicable to contracted health care providers shall be incorporated into the PIHP's Provider Manual or posted to the PIHP's website.
   b. The policies and procedures of the PIHP shall not conflict with or override any term of a contract, including contract fee schedules.

xxvi. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

xxvii. 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 IV.H.4 Provider Payments* of the PIHP Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the PIHP 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 *Section VII. Attachment G. Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the PIHP and provider have mutually agreed to an alternative reimbursement arrangement. When a PIHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

xxviii. Clinical Records Requests for Claims Processing: The contract shall indicate that the PIHP 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).

xxix. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the PIHP 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 Medically Necessary 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.

xxx. Physician Advisor Use in Claims Dispute: The contract must indicate that the PIHP 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.

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

i. 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 PIHP'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 [PIHP's] contract with NC DHHS could result in liability for money damages, including civil or criminal penalties and sanctions under state and/or federal law.

ii. 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 PIHP so long as the member is eligible for coverage.

iii. Liability

The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [PIHP], 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 [PIHP] or any judgment rendered against the [PIHP].

iv. 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 [PIHP] 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, LGBTQ status, or disability.

v. 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) program~~s~~. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

vi. 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 [PIHP and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [PIHP 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:

1. The United States Department of Health and Human Services or its designee;
2. The Comptroller General of the United States or its designee;
3. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee
4. The Office of Inspector General
5. North Carolina Department of Justice Medicaid Investigations Division
6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
7. The North Carolina Office of State Auditor, or its designee
8. A state or federal law enforcement agency.
9. 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.

vii. Prompt Claim Payments.

PIHP shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The [Provider] shall submit all claims to the [PIHP] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim within this time 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.

1. The [PIHP] shall within eighteen (18) Calendar Days of receiving a 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.

2. The [PIHP] shall pay or deny a Clean Claim at lesser of thirty (30) Calendar Days of receipt of the Claim or the first scheduled provider reimbursement cycle following adjudication.
3. A medical pended Claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
4. If the requested additional information on a Claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [PIHP] shall deny the claim.
5. The [PIHP] shall reprocess claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).
6. If the [PIHP] fails to pay a clean claim Clean Claim in full pursuant to this provision, the [PIHP] shall pay the [Provider] interest and penalties. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the Claim should have been paid or was underpaid.
7. Failure to pay a Clean Claim within thirty (30) days of receipt will result in the [PIHP] paying the [Provider] penalties equal to one (1) percent of the total amount of the Claim per day beginning on the date following the day on which the Claim should have been paid or was underpaid.
8. The [PIHP] shall pay the interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to request the interest or the liquidated damages.

viii. 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).

ix. Tobacco-free Policy.

The contract with a provider shall at a minimum include the following in relation to the implementation of a tobacco-free policy unless the provider is a residential facility provider described below.

[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 tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting [Provider] from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients [Provider] serves.

Contracts with facilities that are owned or controlled by the provider, and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a 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) Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by [Provider].
(2) For outdoor areas of campus, [PROVIDER] shall:
    i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and
    ii. Prohibit staff/employees from using tobacco products anywhere on campus.

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Section VI. First Revised and Restated Attachment G. Addendum for Indian Health Care Providers

The PIHP shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. **Purpose of Addendum; Supersession.**
   The purpose of this PIHP Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between _____ (herein "PIHP") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the PIHP's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions. [9]

2. **Definitions.**
   For purposes of this Addendum, the following terms and definitions shall apply:
   a. "Indian" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:
      i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
      ii. Is an Eskimo or Aleut or other Alaska Native;
      iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;
      iv. Is determined to be an Indian under regulations issued by the Secretary.
      v. The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
   b. "Indian Health Care Provider (IHCP)" means 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 those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).).
   c. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid Managed Care contract.
   d. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.
   e. "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).).
   f. "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

g. “Tribal organization” has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).).

h. “Urban Indian organization” has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).).

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

a. IHS.

b. An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §5301 et seq.

c. A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§ 5301 et seq.

d. A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

e. An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost Sharing Exemption for Indians; No Reduction in Payments.

a. The PIHP shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

b. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. §447.53 and §457.535.

5. Agreement to Pay IHCP.

a. The PIHP shall pay the IHCP for covered services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and §457.1209.

b. The State shall make a supplemental payment to the IHCP to make up the difference between the amount the PIHP pays and the amount the IHCP would have received under FFS or the applicable encounter rate published annually by the IHS if the amount the IHCP receives from the PIHP is less than the amount they would have received under FFS or the applicable encounter rate.

6. Persons Eligible for Items and Services from IHCP.

a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP’s programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

b. No term or condition of the PIHP’s network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The PIHP acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals

eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

7. Applicability of Federal Laws not Generally Applicable to other Providers.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving PIHP members. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

8. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a PIHP to collect or remit any federal, state, or local tax.

9. Insurance and Indemnification.

a. Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the PIHP network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 5301, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the PIHP will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 5301, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the PIHP network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the PIHP will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the PIHP network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

10. Licensure and Accreditation.

Pursuant to 25 U.S.C. §§ 1621t and §1647a, the PIHP shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the PIHP shall not require the licensure

of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

11. Dispute Resolution.

In the event of any dispute arising under the PIHP's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the PIHP's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

12. Governing Law.

The PIHP's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the PIHP's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

13. Medical Quality Assurance Requirements.

To the extent the PIHP imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

14. Claims Format.

The PIHP shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

15. Payment of Claims.

The PIHP shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c) and §457.1209 and shall pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

16. Hours and Days of Service.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the PIHP as to its hours and days of service. At the request of the PIHP, such IHCP shall provide written notification of its hours and days of service.

17. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the PIHP.

18. Sovereign Immunity.

Nothing in the PIHP's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

19. Endorsement.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the PIHP.

APPROVALS

For the PIHP: **For the IHCP:**

*Date:*_____ *Date:* _____

*Signature:*_____ *Signature:*_____

Applicable Federal Laws Referenced in Section 8 of this Addendum

( ) The IHS as an IHCP:

Anti-Deficiency Act, 31 U.S.C. § 1341;
ISDEAA, 25 U.S.C. § 5301 et seq.;
Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
IHCIA, 25 U.S.C. § 1601 et seq.

(a) An Indian tribe or a Tribal organization that is an IHCP:

1) ISDEAA, 25 U.S.C. § 5301 et seq.;
2) IHCIA, 25 U.S.C. § 1601 et seq.;
3) FTCA, 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
6) HIPAA, 45 C.F.R. Parts 160 and 164.

(b) An urban Indian organization that is an IHCP:

IHCIA, 25 U.S.C. § 1601 et seq.
Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
HIPAA, 45 C.F.R. Parts 160 and 164.

Section VI. First Revised and Restated Attachment H. Provider Appeals

The following items outlined in Table 1 are the reasons for which the PIHP must allow a provider to appeal a decision adverse to the provider made by the PIHP, which is separate from an Adverse Benefit Determination issued to a Member, which may only be appealed with written permission of the Member/LRP. The PIHP shall provide an appeals process to providers in accordance with *Section IV.H.5. Provider Grievances and Appeals.*

Section VI. First Revised and Restated Attachment H. Table 1: Provider Appeals	
Reference Number	**Appeal Criteria**
For Participating Providers	
1	A Participating Provider has the right to appeal certain actions taken by the PIHP. Provider appeals to the PIHP shall be available for the following reasons: a) Finding of or recovery of an overpayment by the PIHP; b) Withhold or suspension of a payment related to waste or abuse concerns; c) Contract termination for cause or finding of contract violation d) Corrective action by the PIHP e) Determination to de-certify an AMH+ or CMA
For Non-Participating Providers	
2	A Non-Participating Provider may appeal certain actions taken by the PIHP. Appeals to the PIHP shall be available to a Non-Participating Provider for the following reasons: a) Disputes regarding an out-of-network payment arrangement, such as a single-case agreement b) Finding of waste or abuse by the PIHP; and c) Finding of or recovery of an overpayment by the PIHP

Section VI. First Revised and Restated Attachment I. Reporting Requirements

The following tables detail the reports that the PIHP must submit to the Department. The Department will provide additional details on report format, fields, and frequency after Contract Award.

The PIHP shall submit select reports, as identified in *First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements* and *First Revised and Restated Attachment I. Table 2: PIHP Data Extracts*.

The Department will provide additional details and on report format, fields and frequency after Contract Award.

1. Although the State has indicated the reports that are required, the PIHP may suggest additional reports.
2. As part of Readiness Review, the PIHP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. The PIHP shall submit complete and accurate data required by the Department for tracking information on Members obtaining Medicaid in the PIHP and with providers contracted to provide those services.
    a. This information shall include information on Member eligibility for services, Member demographics, adverse events and service outcomes for Members served by the PIHP; and in-reach visits, diversion activities, transition planning and leasing and service information for individuals transitioning out of State hospitals and transitioning out of or diverted from adult care homes.
4. The PIHP shall submit all data on a schedule provided by the Department and shall participate in data quality improvement initiatives specified by the Department.
5. The PIHP shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to the Department.
6. The PIHP shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to the Department.

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
A. Administration and Management		
1. PIHP Operating Report	Annual report of each entity identified under the PIHP Operating Report, providing evidence of PIHP oversight activities and entity performance (i.e., metrics, CAPs, sanctions).	Annually
B. Members		
1. 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.	Quarterly
2. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PIHP including the total number of appeal and grievance requests filed with the PIHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Quarterly
3. PIHP Enrollment Summary Report	Monthly summary report highlighting key member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid eligibility category, number of Member welcome packets and ID cards sent, and time to distribute Member welcome packets.	Monthly

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
4. 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).	Weekly
5. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
C. Benefits		
1. Institute of Mental Disease (IMD) Report	Bi-Weekly summary of Members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-Weekly
2. EPSDT Reports	Quarterly report listing volume of approvals and denials, types of services required, and total paid claims.	Quarterly
3. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver reserved capacity, and list of Members on the Registry of Unmet Needs (waiting list). Report can be included with TP Innovations Waiver Slot and Waiting List Report.	Monthly
4. Monthly TCL Report	Monthly report containing the names and Member Medicaid ID numbers of the Transitions to Community Living Initiative in the PIHP's Region.	Monthly
5. Monthly CWCN	Monthly report containing the names and member Medicaid ID numbers, and all data fields as outlined in the approved DHHS CWCN data template of members identified as CWCN per the PIHP Plan's Region.	Monthly
6. Ongoing Transitions of Care Status Reports	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the PIHP on an ongoing basis.	Monthly
D. Care Management and Care Coordination		
1. Care Needs Screening Report	Quarterly report of Member screening results, including Healthy Opportunity & Care Needs Screening of Members.	Quarterly
2. High Needs Member Follow-up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly
3. TCM Provider Status Change Report	Monthly reporting on tracking TCM provider status changes and the associated decision reasoning.	Monthly

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
4. TCM Provider Contracting and Integration Report	Weekly TCM Provider contracting and integration status report.	Weekly
E. In-Reach and Transitions		
1. IDD In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	Quarterly
2. SED In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; To be reported overall, by diagnosis (I/DD, TBI, SMI, SED), and by setting (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH). Average length of stay; total number of members and percentage in PRTF, members under age 18 in State psychiatric facility, and members receiving residential treatment levels II/program type III, and IV.	Quarterly
3. TBI In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported	Quarterly

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	
F. Providers		
1. Reserved.		
2. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
3. 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.	Annually
4. 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. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
5. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and corresponding statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
6. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' 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.	Quarterly
7. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
8. Capitation Reconciliation Report	Monthly report to inform the State of any capitation-related payment discrepancies observed. PIHPs will include records of members where no payment was received from the State or payment received differed from the amount expected. PIHPs will only include member records with discrepancies on this report to the State. The PIHP Capitation Reconciliation Report will be submitted on a monthly cadence. PIHPs will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
8. Reserved		
9. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
10. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
11. Reserved.		
G. Quality and Value		
1. QAPI Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
2. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
3. Quality Measures Report	Annual PIHP performance on quality measures.	Annually
4. Reserved.		
5. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
H. Stakeholder Engagement		
1. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PIHP to collaborate with county organizations to address issues by county/Region.	Monthly
2. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
3. 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.	Quarterly
I. Program Administration		
1. Reserved		
2. Reserved		
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
J. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the PIHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential fraud, and actual waste and abuse by Participating Providers, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential fraud, and actual waste and abuse by Members, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
4. 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.	Monthly
5. Reserved.		
6. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly and Quarterly
K. Financial Requirements		
1. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted monthly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others.	Monthly
2. PIHP Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the PIHP template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually

Section VI. First Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
3. Claims Monitoring Report*	Weekly summary of BH claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional or, institutional. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period. Note: Ad-hoc upon request. Ad hoc report will be requested no less than 10 days in advance or mutually agreed upon timeframe *For BH claims only	Weekly
4. Payer Initiated Claim Adjustment Report	Ad hoc report required in the event the State deems necessary or a provider escalates grievance related to PIHP claim adjustment processing. The PIHP must complete required information within the report for the Department to validate appropriate claim adjustment was complete.	Ad hoc

Section VI. First Revised and Restated Attachment I. Table 2: PIHP Data Extracts		
PIHP Report Name	**PIHP Report Description**	**Frequency**
A. Members		
1. PIHP Enrollment Extract	Weekly detail 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.	Weekly
2. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of Adverse Benefit Determination issued by the PIHP to a Member and each grievance received by PIHP from Members.	Daily
3. Monthly 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. *Note* If the date the extract is being submitted is prior to July 1, 2022, the extract would include member eligibility as of July 1, 2022.	Monthly

Section VI. First Revised and Restated Attachment I. Table 2: PIHP Data Extracts		
PIHP Report Name	**PIHP Report Description**	**Frequency**
B. Benefits and Care Management		
1. Medical Prior Authorization Extract*	Weekly extract providing information on behavioral health prior approval requests by individual Member, service type, determination date, and approval status. *For BH prior authorization requests only	Weekly
2. Care Management Reason Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly
C. Providers		
1. Reserved.		

Section VI. First Revised and Restated Attachment K. Managed Care Terminology Provided to the PIHP for Use with Members Pursuant to 42 C.F.R. § 438.10

Key terms below are defined as they are intended to be used with Members and do not conflict with the definitions in *Section II. Definitions and Abbreviations* of this contract.

1. **Appeal:** If NC Medicaid Direct makes a decision you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an appeal when you do not agree with your health care service being denied, reduced, stopped or limited. When you ask NC Medicaid Direct for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." Appeals and grievances are different.
2. **Copayment (Copay):** An amount you pay when you get certain health care services or a prescription.
3. **Durable Medical Equipment (DME):** Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness or an injury.
4. **Emergency Medical Condition:** A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.
5. **Emergency Medical Transportation:** Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.
6. **Emergency Department Care (or Emergency Room Care): Care** you receive in a hospital if you are experiencing an emergency medical condition.
7. **Emergency Services:** Services you receive to treat your emergency medical condition.
8. **Excluded Services:** Services that are not covered by NC Medicaid Direct.
9. **Grievance:** A complaint about your provider, care or services. Contact NC Medicaid Direct and tell them you have a "grievance" about your services. Grievances and appeals are different.
10. **Habilitation Services and Devices:** Health care services that help you keep, learn or improve skills and functioning for daily living.
11. **Health Insurance:** A type of insurance coverage that helps pay for your health and medical costs. Your Medicaid coverage is a type of health insurance.
12. **Home Health Care:** Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.
13. **Hospice Services:** Special services for patients and their families during the final stages of terminal illness and after death. Hospice services include certain physical, psychological, social and spiritual services that support terminally ill individuals and their families or caregivers.
14. **Hospitalization:** Admission to a hospital for treatment that lasts more than 24 hours.
15. **Hospital Outpatient Care:** Services you receive from a hospital or other medical setting that do not require hospitalization.
16. **Medically Necessary:** Medical services, treatments or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
17. **Network (or Provider Network):** A group of doctors, hospitals, pharmacies and other health professionals who have a contract with NC Medicaid Direct to provide health care services for members.
18. **Out-of-Network Provider (or Non-participating Provider):** A provider that is not in NC Medicaid Direct's provider network.

19. **Network Provider (or Participating Provider):** A provider that is in NC Medicaid Direct's provider network.
20. **Physician Services:** Health care services you receive from a physician, nurse practitioner or physician assistant.
21. **Health Plan (or Plan):** Organization providing you with health insurance.
22. **Prior Authorization (or Preauthorization):** Approval you must have from NC Medicaid Direct before you can get or continue getting certain health care services or medicines.
23. **Premium:** The amount you pay for your health insurance every month. Most Medicaid beneficiaries do not have a premium.
24. **Prescription Drug Coverage:** Refers to how NC Medicaid Direct helps pay for its members' prescription drugs and medications.
25. **Prescription Drugs:** A drug that, by law, requires a provider to order it before a beneficiary can receive it.
26. **Primary Care Provider (or Primary Care Physician):** The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits, visits to help you manage an illness like diabetes.) Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. Your PCP should be your first call for care before going to the emergency department.
27. **Provider:** A health care professional or a facility that delivers health care services, like a doctor, clinician, hospital or pharmacy.
28. **Rehabilitation Services and Devices:** Health care services and equipment that help you recover from an illness, accident, injury or surgery. These services can include physical or speech therapy.
29. **Skilled Nursing Care:** Health care services that require the skill of a licensed nurse.
30. **Specialist:** A provider who is trained and practices in a specific area of medicine.
31. **Urgent Care:** Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury.

Section VI. Attachment L. Policies, 2. First Revised and Restated AMH+ Practice and CMA Certification Policy

a. Background

i. Prior to PIHP launch, the Department will implement a direct process to certify provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs as described below and in the BH I/DD Tailored Plan Provider Manual for Tailored Care Management https://medicaid.ncdhhs.gov/tailored-care-management his certification process will require providers to apply to the Department and be assessed against the criteria in this policy.

1. AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the BH I/DD Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD diagnosis; an I/DD; or a TBI. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at BH I/DD Tailored Plan launch, the Department's vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.
2. CMAs will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid or State-funded services, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

ii. Beginning at BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan will assume responsibility for certifying provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs. The BH I/DD Tailored Plan must assess providers applying to become an AMH+ practice or CMA against the criteria in this policy. The Department will release additional guidance prior to BH I/DD Tailored Plan launch to describe the parameters for certification by BH I/DD Tailored Plans.

b. Eligibility

To become certified as an AMH+ practice or CMA, an organization must meet the requirements for an AMH+ practice or CMA, given at *Section IV.G Care Management and Care Coordination.*

c. Organizational Standing and Experience Criteria

i. The organization must demonstrate that its past experience positions it to provide Tailored Care Management to the BH I/DD Tailored Plan population, specifically the subpopulation(s) for which it proposes to become a certified Tailored Care Management provider.

ii. All organizations entering the certification process, including prospective AMH+ practices, will be required to indicate one or more of the following specialty designation type(s):

1. Mental health and SUD

a. Adult
b. Child/adolescent

2. I/DD (not enrolled in the Innovations Waiver
3. TBI (not enrolled in the TBI Waiver)
4. Innovations Waiver
5. Co-occurring I/DD and behavioral health
    a. Adult
    b. Child/adolescent

iii. Organizations that specialize in BH must demonstrate their capacity to serve populations with both mental health and SUD needs. The organization must offer an array of services that is aligned with the needs of the target population(s) in North Carolina. The Department has a general expectation that each organization will be able to show at least a two (2) year history of providing services to the BH I/DD Tailored Plan population in North Carolina. However, the Department encourages organizations to build new capacity for Tailored Care Management.

iv. The organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.

v. The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business.

vi. Tailored Care Management must be recognized by the organization's leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.

vii. The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.

viii. The Department (prior to PIHP launch) or PIHP (beginning at PIHP launch) will look for evidence of a strong governance structure.

ix. Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.

d. Staffing Criteria

i. AMH+ practices and CMAs must meet the same care management staffing requirements as the BH I/DD Tailored Plan. See *Section IV.B.3 Staffing and Facilities.*

ii. The evaluation of each provider organization's application for AMH+ or CMA certification will include gaining an understanding of the role of any CIN or other partners in supporting or facilitating Tailored Care Management.

1. Where the AMH+ practice or CMA proposes to rely on CIN or Other Partner-employed care managers to carry out Tailored Care Management, the Department (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan (beginning at BH I/DD Tailored Plan launch) will look to ensure that care management is sufficiently integrated with the organization's practice team, as Tailored Care Management requires.
2. Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to:
    a. Approve hiring/placement of a care manager and
    b. Require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory.

iii. CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support the Tailored Care Management model.
   1. Arrangements with CINs or Other Partners must include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid and/or has supported similar efforts in other states.
   2. Any subsidiaries of PIHPs, BH I/DD Tailored Plans or other health plans may not be considered CINs or Other Partners for the purposes of Tailored Care Management with the following exception:
      i. That AMH+ practice or CMA may decide to enter into arrangements with a BH I/DD Tailored Plan as an "Other Partner" for use of its IT products or platforms for care management, in order to meet the care management data system requirements.
   3. AMH+ practices and CMAs must meet the same requirements for clinical consultants as the BH I/DD Tailored Plan. See *Section IV.G.2 Tailored Care Management.*

e. Population Health and HIT Criteria

i. The AMH+ or CMA must have implemented an EHR or a clinical system of record that is in use by the AMH+ practice or CMA's providers that may electronically record, store, and transmit their assigned Members' clinical information, including medication adherence.

ii. The AMH+ or CMA must use a single care management data system, whether or not integrated within the same system as the EHR or clinical system of record, which allows care managers to perform the following care management functions, at minimum:
   1. Maintain up-to-date documentation of Tailored Care Management Member lists and assignments of individual Members to care managers;
   2. Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
   3. Electronically document and store the Care Plan or ISP;
   4. Incorporate claims and encounter data;
   5. Provide role-based access to and electronically share, if requested the Member's records with the Member's care team to support and coordinate care management, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
   6. Track referrals; and
   7. Allow care managers to:
      a. Identify risk factors for individual Members;
      b. Develop actionable Care Plans and ISPs;
      c. Monitor and quickly respond to changes in a Member's health status;
      d. Track a Member's referrals and provide alerts where care gaps occur;
      e. Monitor a Member's medication adherence;
      f. Transmit and share reports and summary of care records with care team members; and
      g. Support data analytics and performance and send quality measures (where applicable).

iii. The AMH+ practice or CMA must receive and use enrollment data from the PIHP to empanel the population in Tailored Care Management. To support outreach, engagement, assessment, and care planning, the AMH+ practice or CMA (or CIN or Other Partner on its behalf) must be able to:
   1. Receive, in machine-readable format, and maintain up-to-date records of acuity tiers by Member, as determined and shared by the BH I/DD Tailored Plan;
   2. Receive, in machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the BH I/DD Tailored Plan; and
   3. Electronically reconcile the Tailored Care Management assignment lists received from the BH I/DD Tailored Plan with its list of Members for whom it provides Tailored Care Management.

iv. The same requirements for use of ADT information apply at the PIHP level and AMH+ or CMA level. See *Section IV.G.2 Tailored Care Management.*

v. The same requirements for use of "NCCARE360" apply at the PIHP level and AMH+ or CMA level. See *Section IV.G Care Management and Care Coordination.*

vi. The Department expects that during the first two contract years, PIHP, AMH+ practices, and CMAs a will rely on the standardized acuity tiering methodology described above Section *IV.G.2 Tailored Care Management* as the primary method for segmenting and managing their populations.

vii. As described in *IV.G.2 Tailored Care Management*, the PIHP will have the option of establishing their own risk stratification methodologies beyond acuity tiering; if they do so, they will be required to share all risk stratification results and methodologies used with AMH+ practices and CMAs.

viii. By Contract Year 3, as the Tailored Care Management model matures, AMH+ practices and CMAs will be expected to develop their own risk stratification approach, refining the data and risk stratification scores they receive from the PIHP to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices and CMAs' use of Member registries to track Members by condition type/cohort is encouraged, but not required.

ix. Annually, the AMH+ practice or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of Members and refine the services as necessary. The AMH+ practice or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.

f. Quality Measurement Criteria

i. After the launch of the PIHP, AMH+ practices and CMAs will be required to gather, process, and share data with the PIHP for the purpose of quality measurement and reporting.

ii. The Department will publish quality measure requirements each year. Elements of the list may be modified on a quarterly basis, but new measures will be added only during annual updates.

iii. AMH+ practices and CMAs may need to perform tasks including:

1. Abstracting data from Member charts;
2. Performing quality assurance to validate the accuracy of data in Member charts that is used for quality measurement purposes;
3. Using additional codes to fully document Member status and needs in order to improve the accuracy of quality measurement; and
4. Explaining to Members the purpose of certain state-sponsored surveys, how the state and PIHP will use survey results, and how their information will be kept confidential.

iv. As covered in *Section IV.G Care Management and Care Coordination,* BH I/DD Tailored Plans will be required to share interim performance reports with AMH+ practices and CMAs.

g. Other Tailored Care Management Criteria

i. AMH+ practices and CMAs must develop policies for communicating and sharing information with Members, their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.

ii. AMH+ practices and CMAs must meet the same contact requirements as the BH I/DD Tailored Plan*. See Section IV.G Care Management and Care Coordination.*

iii. AMH+ practices and CMAs must meet the same requirements for Care Management Comprehensive Assessment that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*

iv. AMH+ practices and CMAs must meet the same requirements for Care Plans and ISPs that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*

v. AMH+ practices and CMAs must meet the same requirements for the composition of a care team that apply at the BH I/DD Tailored Plan level.

vi. By PIHP launch, the AMH+ practice or CMA must demonstrate the ability to electronically and securely transmit the Care Plan or ISP to each member of the multidisciplinary care team**.** *See Section IV.G Care Management and Care Coordination.*

vii. AMH+ practices and CMAs must meet the same requirements for ongoing care management that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*

viii. AMH+ practices and CMAs must meet the same requirements related to addressing Unmet Health-Related Resource Needs that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*

ix. AMH+ practices and CMAs must meet the same requirements for transitional care management that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*

x. Care managers based at AMH+s and CMAs, as well as any supporting CINs or Other Partners, will be required to undergo the same training requirements as care managers based at BH I/DD Tailored Plans. *See Section IV.G Care Management and Care Coordination.*

xi. AMH+ practices and CMAs must meet the same requirements for care coordination for members obtaining 1915(c) Innovations and TBI waiver services and 1915(i) service that that apply at the PIHP level. See *Section IV.M.3. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver.*

xii. AMH+ practices and CMAs must meet the same requirements for care coordination for members obtaining 1915(i) services that that apply at the PIHP level. See *Section IV.M.3. Additional Care Coordination Functions for Members Obtaining 1915(i) Services.*

Section VI. Attachment L. Policies, 3. First Revised and Restated Uniform Credentialing and Re-credentialing Policy for Medicaid

a. Background

This Uniform Credentialing and Re-credentialing Policy for Medicaid Providers outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a PIHP in determining whether to allow a provider to be included in the PIHP's Network. This is based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider. The PIHP shall also have the authority to select which providers may enroll in the PIHP Closed Network consistent with the PIHP selection and retention criteria. Enrollment in the NC Medicaid Direct Program is distinct from Enrollment in the PIHP Closed Network. The PIHP has the authority to maintain a closed network for all services as set forth in N.C.G.S. § 108D-1(6). The Uniform Credentialing and Re-credentialing Policy also outlines the expectations of the Department with regard to the process and standards utilized by the PIHP in selection and retention of network providers for Medicaid BH and I/DD services.

b. Scope

This Policy applies to the PIHP and covers credentialing and re-credentialing policies for both individual and organizational providers. The Policy shall apply to all types of providers, including but not limited to, mental health, SUD, and HCBS [42 C.F.R. 438.12(a)(2); 42 C.F.R. § 438.214(b)(1)].

c. Policy Statement

The PIHP shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures relating to initial or continued contracting with their medical services providers consistent with the Department's Credentialing and Re-credentialing Policy.

d. Centralized Provider Enrollment and Credentialing

i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:

1. The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid Direct for BH and I/DD Services.
    a. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.
    b. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.
2. The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid Services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).
3. The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the NCQA as the Plan accrediting organization. The applicable data and processing standards shall be consistent with current waivers

or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.

4. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid Enrolled provider, with the application serving for enrollment as PIHP providers.
    a. The Department shall not mandate PIHP providers enrolled with the State to provide State-funded services.
5. Providers will be reverified and recredentialed as permitted, by the Department in the Contract.
6. A PIHP shall use its Provider Credentialing and Re-credentialing Policy to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the PIHP will routinely evaluate its Provider Network to confirm a provider's continue active status as a Medicaid Enrolled provider in accordance with the standards contained in this Policy.
7. The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers. The PIHP shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

e. Provider Credentialing and Re-credentialing Policy

i. The PIHP shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:
    1. Meet the requirements specified in 42 C.F.R. § 438.214;
    2. Meet the requirements specified in this Contract;
    3. Follow this Policy and any applicable requirements from the Contract, and address acute, mental health, substance use disorders, and long-term services and supports providers;
    4. Establish that the PIHP shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.
    5. Establish a documented process for determining if a provider is an active Medicaid Enrolled provider and therefore eligible for contracting;
    6. Prohibit PIHP from discriminating against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
    7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
    8. Prohibit PIHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
    9. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and
    10. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH and I/DD services. At a minimum, these standards shall assess a provider's ability to deliver care.
    11. Describe the information that providers will be requested to submit as part of the contracting process.
    12. Describe the process by which the PIHP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).
    13. If PIHP requires a provider to submit additional information as part of its contracting process, the PIHP's policy shall include a description of all such information.
    14. PIHP shall re-credential providers as follows:

a. The PIHP shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
b. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.

15. PIHP shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.
16. PIHP shall have discretion to make network contracting decisions consistent with the Policy.

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Section VI. Attachment L. Policies, 4. First Revised and Restated Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards

A. Background

The BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards provides the PIHPs with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

B. Behavioral Health Services

i. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.

ii. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.

iii. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.

iv. Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification services): a Medicaid crisis service for the purpose of network adequacy standards.

v. Ambulatory withdrawal management with extended on-site monitoring: a Medicaid crisis service for the purpose of network adequacy standards.

vi. Clinically managed residential withdrawal services (social setting detoxification): a Medicaid crisis service for the purpose of network adequacy standards.

vii. Medically Monitored Inpatient Withdrawal Services (Non-Hospital Medical Detoxification): a crisis service for the purpose of network adequacy standards.

viii. Medically managed intensive inpatient withdrawal services (acute care hospitals with adult inpatient substance use beds): a Medicaid crisis service for the purpose of network adequacy standards.

ix. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.

x. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.

xi. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xii. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xiii. Medically managed intensive inpatient services (Acute Care Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.

xiv. Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.

xv. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xvi. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xvii. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xviii. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xix. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xx. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xxi. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.

xxii. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xxiii. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxiv. Urgent Care for Mental Health:

1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.

xxi. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.

xxii. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxiii. Urgent care for SUD:

1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.

2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.

xxiv. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

xxv. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

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Section VI. Attachment L. Policies, 6. COVID-19 Public Health Emergency Managed Care Policy

The Department's goal in implementing Medicaid Managed Care is to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which purchases health while addressing both medical and non-medical drivers of health. During the ongoing response to the Coronavirus-19 (COVID-19) pandemic, it is critical that the Department work with Contractor to institute efforts to keep Members healthy by taking steps to protect Members from infectious disease, providing access to testing, treatment and vaccine administration for COVID-19, ensuring care for ongoing chronic or acute conditions, and supporting Members and providers through the Public Health Emergency Unwinding.

1. Member materials
   i. No later than March 15, 2023, the PIHP shall begin including inserts in the Member Welcome Packet and handbooks that address COVID-19 and the COVID-19 Federal Public Health Emergency Unwinding (PHE Unwinding).
      a. The inserts must include links to Federal and State guidance and resources, including information on the PHE and impact of the PHE unwinding on Medicaid eligibility.
      b. The PIHP may distribute COVID-19 inserts to Members without prior approval from the Department, however, the PIHP shall make changes to the inserts as requested by the Department after initial distribution.
   ii. The PIHP may include informational materials on COVID-19 when sending other member communications, including but not limited to explanations of benefits and communications for appeals and grievances.
   iii. No later than January 1, 2023, the PIHP shall make available within two clicks of the homepage of its member website information regarding changes to benefits, eligibility, and enrollment during the term of this Amendment.
      a. The PIHP shall include within one click of the homepage information on what Members should do if they are experiencing symptoms of COVID-19.
      b. The PIHP shall include link(s) on its member website to the State website on the COVID-19 response and the PHE Unwinding.
   iv. No later than January 1, 2023, the PIHP shall update member smartphone apps to include information on benefit, eligibility and enrollment changes during the term of this Amendment, what the Member should do if they experience symptoms of COVID-19, and links to the State website on the COVID-19 response and the PHE Unwinding.
   v. All updates to Member materials will be subject to language and accessibility requirements in *Section IV.E.2.i* . of the Contract.
   vi. The Department reserves the right to review and request changes to the PIHP's COVID-19 updates to any required member materials or marketing materials defined in the Contract.

2. Advisory Committees
   The PIHP shall consult with its CFAC on the PIHP's response to COVID-19 and the PHE Unwinding.

3. Call Centers
   i. No later than January 1, 2023, the PIHP shall ensure all call center staff are aware of and are prepared to answer Member questions related to changes in eligibility, enrollment, benefits and provider networks related to COVID-19 and the PHE Unwinding.
   ii. The PIHP shall ensure Member services call center and behavioral health crisis line staff:

a. Are aware of and can direct Members to further information on statewide programs and initiatives related to COVID-19, best practices for limiting disease spread, testing sites, vaccine administration, and policy changes stemming from COVID-19 and the PHE Unwinding;
b. Are able to refer Members to housing specialists, as needed;
c. Are able to assist Members in finding providers offering telehealth and other virtual care;
d. Are able to inform Members of resources to meet unmet health-related resource needs, such as food, housing and transportation, and direct Members to additional information on these resources; and
e. Are able to link to Member's Tailored Care Manager, as applicable.

iii. The PIHP shall update call center scripts to include the information required in this Section and submit to the Department as defined in the Contract.

4. Provider Communications
   i. The PIHP shall post through appropriate channels provider-focused guidance developed by the Department in response to COVID-19 including changes to eligibility, benefits, new Federal and State flexibilities, payment processes, how to comply with Federal and/or State guidance and the PHE unwinding.

5. Provider Payments
   i. The PIHP shall update providers reimbursements, consistent with rate floor requirements, to reflect Department defined COVID-19 related fee schedule changes as defined in the Contract.
   ii. For providers without a rate floor requirement, the PIHP shall adjust negotiated provider reimbursement rates by an amount no less than the associated dollar change in the fee schedule made by the Department in the fee-for-service program in response to COVID-19.

Section VI. Attachment L. Policies, 7. Approved <PIHP 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 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 PIHP 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 PIHP demonstrating such cost effectiveness and clinical effectiveness;
2. Members shall not be required by the PIHP to use the alternative service or setting;
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 PIHP; 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 IV.F. Benefits, the following In Lieu of Services have been approved by the Department: **Individual Plan Tables follow.**

ILOS that have received conditional approval from the Department are effective through December 31, 2023. If the PIHP wishes to continue offering the conditionally approved ILOS beyond December 31, 2023, the PIHP shall resubmit the Department's standardized ILOS Service Request Form at least ninety (90) Calendar Days prior to December 31, 2023.

Attachment L. 7. Approved Alliance Health In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**End Date (Glidepath only)**	**Description**
BCM07-MD_0M4Q_2	Child Assertive Community Treatment	H0040 U5 HA		Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting.
BCM07-MD_0M4Q_13	Long Term Community Supports (LTCS)	T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3		Long Term Community Supports (LTCS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process, choose to access active treatment to assist them with skills to live as

		T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5		independently as possible in the community.
BCM07-MD_0M4Q_1	Enhanced Crisis Response	H2011 U5 U1 (weekly unit)	12/31/2023	This program operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24-7 service delivery.
BCM07-MD_0M4Q_4	In-Home Therapy Services	H2022 HE U5 H2022 TS U5		Children and adolescents in need of individual and family therapy services, parenting and coping strategies due to complex psychosocial situations and/or multisystem involvement.
BCM07-MD_0M4Q_6	Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4		Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities, FCT treats the youth and his/her family through individualized therapeutic interventions.
BCM07-MD_0M4Q_7	Transitional Youth Services (TYS)	H2022 U5		The Transitional Youth Services Program is a home and community-based Outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently.
BCM07-MD_0M4Q_5	Assertive Community Treatment Step Down (ACT-SD)	H0040 U5	12/31/2023	ACT Step-Down (ACT-SD) will be the next lower level of care under ACT. The service will be provided by organizations that meet all of the provider requirements for Assertive Community Treatment (ACT) Team in DMA Clinical Policy 8A-1; ACT-SD will be provided by identified ACT team members within the provider organization.
BCM07-MD_0M4Q_10	Behavioral Health Crisis Assessment and Intervention (BHCAI)	T2016 U5 or T2016 U6		BH CAI is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting.
BCM07-MD_0M4Q_12	Acute and Subacute Services Provided in	RC 0160		This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for

	an Institute for Mental Disease			Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders.
BCM07-MD_0M4Q_8	High Fidelity Wraparound	H0032 - U5		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW.
BCM07-MD_0M4Q_11	Short Term Residential Stabilization	T2016 TF U5		Short Term Residential Stabilization (STRS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active habilitation services and supports to assist them with skill acquisition to live as independently as possible in the community. STRS is a community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD).
BCM07-MD_0M4Q_3	Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis (Residential Services – Complex Needs)	H0018 HA		Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral characteristics.

Attachment L. 7. Approved Eastpointe Human Services In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**End Date (Glidepath only)**	**Description**
BCM07-MD_YK4U_1	Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4		Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions.
BCM07-MD_YK4U_6	Acute and Subacute Services Provided in an Institute for Mental Disease	RC 0160		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.
BCM07-MD_YK4U_4	High Fidelity Wraparound (HFW)	H0032 - U5		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family-driven care to meet the needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education); experience serious emotional or behavioral difficulties; have dual diagnosis (MH and/or SUD, and IDD) with complex needs; are at risk of treatment in PRTFs or other institutional settings; who have been in restrictive residential/institutional care; have high risk medical needs; and/or are aging out of Department of Social Services (DSS) care.
BCM07-MD_YK4U_7	Rapid Care Services	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High		Rapid Care Services allow time for extended assessment which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period of time to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member.
BCM07-MD_YK4U_3	Community Living Facilities and Support (CLFS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4		Residential services and day support to facilitate optimal community-based living in least restrictive environment. Level 1 provides supports to families who want to keep loved one at home but require treatment support to do so. Other levels provide residential support. Some small non-family living environments are used to avoid or stepdown from ICF-IDD settings. Provide meaningful and community-integrated day through therapeutic supports and services.

		T2016 U5 U6 – Level 5		

Attachment L. 7. Approved Partners Health Management In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**End Date (Glidepath only)**	**Description**
BCM07-MD_4DII_12	Long Term Community Supports (LTCS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5		Long Term Community Supports (LTCS) consist of a broad range of residential and day services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active treatment to assist them with skills to live as independently as possible in the community. LTCS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD).
BCM07-MD_4DII_5	Rapid Response	S9484 U5 (low) S9484 HK U5 (high)		Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing Agency or licensed alternative family living (AFL) homes that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment, and prevent or minimize the need for out-of-home placements.
BCM07-MD_4DII_10	In-Home Therapy Services	H2022 HE U5 U1 H2022 HE U5 TS		In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the needs and prevent future incidents.
BCM07-MD_4DII_1	Assertive Community Treatment Step Down (ACT-SD)	H0040 U5	12/31/2023	ACT Step-Down (ACT-SD) is the next lower level of care under ACT Team and supports individuals who no longer need the full array of ACT Team services but are not yet prepared to move to office-based care. ACT-SD provides

				longer-term clinical, and recovery supports of moderate intensity.
BCM07-MD_4DII_3	Behavioral Health Urgent Care (BHUC)	T2016 U5		Behavioral Health Urgent Care (BHUC) A designated intervention/treatment location, known as a Behavioral Health Urgent Care (BHUC) that is an alternative to any community hospital Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referral.
BCM07-MD_4DII_2	Youth Focused Assertive Community Treatment Team –ACTT Youth-Youth	H0040 U5 HA		Youth Focused Assertive Community Treatment ACTT Youth-Youth) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting.
BCM07-MD_4DII_4	Acute and Subacute Services Provided in an Institute for Mental Disease	RC 0160		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.
BCM07-MD_4DII_15	Rapid Care Services Children and Adults with Mental Illness and/or Substance Use Disorders	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High		Rapid Care Services allow time for extended assessment which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member.
BCM07-MD_4DII_8	Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4		Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.
BCM07-MD_4DII_14	Residential Services-Complex Needs	H0018 HA		Residential Services – Complex Needs is a short-term residential treatment service focused on treatment of member with cooccurring conditions and complex presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.
BCM07-MD_4DII_11	Individual Rehabilitation,	H2017 U5		The purpose of this service is to enhance, restore and/or strengthen the skills needed to

	Coordination, & Support Services			promote and sustain independence and stability within the individual's living, learning, social, and work environments. IRCS is a skill building service, not a form of psychotherapy or counseling.
BCM07-MD_4DII_9	High Fidelity Wraparound (HFW)	H0032 - U5		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, physical health, child welfare, juvenile/criminal justice, and education), experience serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in PRTFs or other institutional settings, and/or are aging out of Department of Social Services (DSS) care.
BCM07-MD_4DII_13	Young Adults in Transition	H2022 U5		The Young Adults in Transition service is a home and community-based outpatient intervention that supports transition-age members (ages 16-24) with behavioral health diagnoses of mental health disorder, with or without a co-occurring substance use disorder, in reestablishing the knowledge and skills necessary to live independently.

Attachment L. 7. Approved Sandhills Center In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**End Date (Glidepath only)**	**Description**
BCM07-MD_7HQF_6	Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4		Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions.
BCM07-MD_7HQF_4	Institute for Mental Disease (IMD)	RC 0160		IMD provides 24-hour access to continuous intensive evaluation and treatment delivered for acute and subacute inpatient psychiatric or substance use disorders (SUDs). Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist.
BCM07-MD_7HQF_3	Behavioral Health Urgent Care (BHUC)	T2016 U5		BHUC is an alternative to any community hospital Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referral.

BCM07-MD_7HQF_5	Long-Term Community Supports	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5		Long Term Community Supports (LTCS) consist of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active treatment to assist them with skills to live as independently as possible in the community.
BCM07-MD_7HQF_1	High Fidelity Wraparound	H0032 – U5		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events.
BCM07-MD_7HQF_2	In-Home Therapy Services (IHTS) Children	H2022 HE U5 H2022 TS U5		In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion.

Attachment L. 7. Approved Trillium Health Resources In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**End Date (Glidepath only)**	**Description**
BCM07-MD_ILJX_2	Child First	H2022 TJ	12/31/2023	Child First is an innovative, home-based, early childhood intervention, embedded in a system of care that works to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among the most vulnerable young children and families.
BCM07-MD_ILJX_6	Behavioral Health Crisis Assessment and Intervention (BH-CAI)	T2016 U5 or T2016 U6 depending on tier		A designated service that is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a

				replacement, to a community hospital Emergency Department.
BCM07-MD_ILJX_5	Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4		Family Centered Treatment is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals' effective practice.
BCM07-MD_ILJX_3	Community Living Facilities and Support (CLFS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5		Community Living Facilities and Supports (CLFS) consist of a broad range of services for adults with developmental disabilities who, through the Person Center Plan (PCP) process, choose to access active treatment to assist them with skills to live as independently as possible in the community.
BCM07-MD_ILJX_1	High Fidelity Wraparound (HFW)	H0032 - U5		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events.
BCM07-MD_ILJX_4	Family Navigator	T2041 U5	12/31/2023	Family Navigators can assist members and families to navigate these challenging times and to understand the changes in systems through lived experience. NC already offers this for adults who experience Mental Health and Substance use disorders using a Peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience IDD or TBI.

Attachment L. 7. Approved Vaya Health In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**End Date (Glidepath only)**	**Description**
BCM07-MD_1EL1_16	Acute and Subacute Services Provided in an Institute for Mental Disease	RC 0160		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 15 days per calendar month in an IMD.
BCM07-MD_1EL1_15	Outpatient Plus	H2021 U5	12/31/2023	Outpatient Plus (“OPT Plus”) is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals of any age with complex clinical needs that basic outpatient therapy cannot adequately address.
BCM07-MD_1EL1_7	Critical Time Intervention	H0032 U5 HK	12/31/2023	Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults ages 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. For this definition, CTI defines a critical transition as occurring within no more than 45 days from the start of service.
BCM07-MD_1EL1_4	Case Support	T1016 U5	12/31/2023	Case support activities are performed by an individual employed by a provider agency. The activities are for members who do not have other services in place that provide this type of clinical support and need help coordinating social determinants of health or healthcare services.
BCM07-MD_1EL1_3	Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)	T2016 U5 or T2016 U6		A designated service that is designed to provide triage, crisis risk assessment, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital emergency department (ED). Individuals receiving this service have primary behavioral health needs and an urgency determination of urgent or emergent. Individuals receiving this service

				will be evaluated, stabilized, and/or referred to the most appropriate level of care.
BCM07-MD_1EL1_10	Family Centered Treatment	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4		Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services.
BCM07-MD_1EL1_6	Residential Services – Complex Needs	H0018 HA		This short-term residential treatment service focuses on members with primary diagnoses of intellectual/developmental disabilities (I/DD) with co-occurring mental health (MH) diagnoses or significant behavioral challenges. The members being served would benefit most from a multi-disciplinary approach with staff that are trained to treat I/DD, MH, and severe behaviors.
BCM07-MD_1EL1_13	Rapid Care Services	S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High		Rapid Care Services allow time for extended assessment, which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period of time to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member. This includes observation in a secure, medically staffed and psychiatrically monitored setting as an alternative to the community hospital/ emergency department (ED).
BCM07-MD_1EL1_1	High Fidelity Wrap - around	H0032U5		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in a Psychiatric Residential Treatment Facility (PRTF) or other institutional settings, or are aging out of Department of Social Services (DSS) care.
BCM07-MD_1EL1_11	In-Home Therapy Services	H2022 HE U5 H2022 TS U5		In-Home Therapy Services (IHTS) consist of evidence-based therapy services and coordination of care interventions provided in

				the home for individuals with complex clinical needs that outpatient therapy alone cannot adequately address in a time-limited fashion.
BCM07-MD_1EL1_8	Enhanced Crisis Response (ECR)	H2011 U5 U1 weekly unit		Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth in the emergency department (ED) or in a non-therapeutic home who are at risk of admission to the ED, the practitioner will respond as soon as possible but no longer than two hours from receipt of the referral. For other referrals, response will be on the same day or by the end of the following day.
BCM07-MD_1EL1_12	Long-Term Community Supports (LTCS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5		Long-Term Community Supports (LTCS) is a community-based comprehensive service for adults (age 22 and older) with intellectual/ developmental disabilities (I/DD) that provides individualized services and supports to a person who would otherwise be institutionalized in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
BCM07-MD_1EL1_5	Child- Focused Assertive Community Treatment	H0040 U5 HA		Child-Focused Assertive Community Treatment (Child ACT) is a team-based, multi-disciplinary approach to serve children in their residential setting. This includes homes, kinship placements, and Department of Social Services (DSS) foster homes, or the service may begin during transition from a therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED).
BCM07-MD_1EL1_14	Transitional Youth Services	H2022 U5		The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses in reestablishing the knowledge and skills necessary to live independently.

BCM07-MD_1EL1_2	Assertive Community Treatment Step Down (ACT SD)	H0040 U5	12/31/2023	ACT SD service supports beneficiaries whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately addressed with Outpatient Therapy alone. ACT SD is a community based, person-centered and recovery focused service designed to assist the beneficiary in maintaining stable functioning and wellness while providing support for continued recovery.
BCM07-MD_1EL1_9	Family Navigator	T2041 U5	12/31/2023	Family Navigators can assist members and families to navigate challenging times and understand the changes in systems through lived experience. NC already offers this for adults who experience mental health and substance use disorders using a peer support model.

Section VI. First Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages

Table 1: Liquidated Damages for Compliance Issues

Section VI. First Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$1,250 per calendar day
2.	Failure to comply with conflict of interest requirements described in *Section III.B.15. Disclosure of Conflicts of Interests* and *Section IV.A.6. Staffing and Facilities.*	$2,500 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.B.16. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition.*	$250 per calendar day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.B.17. Disclosure of Ownership Interest*.	$625 per contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in *Section III.B.46 Subcontractors.*	Up to $12,500 per occurrence
B. Members		
1.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section IV.E.4. Marketing.*	$1,250 per occurrence
2.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section IV.E.1 Eligibility and Enrollment for PIHP.s*	$125 per occurrence per member
3.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in *Section IV.E.3 Member Engagement.*	$125 per occurrence per member
4.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section IV.E.3 Member Engagement.*	Up to $12,500 per occurrence
5.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section IV.E.6. Member Grievances and Appeals.*	$125 per occurrence
6.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$1,250 per occurrence

Section VI. First Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
7.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section IV.E.6. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND $125 per calendar day for each day the PIHP fails to provide continuation or restoration as required by the Department.
8.	Failure to attend mediations and hearings as scheduled as specified in *Section IV.E.6. Member Grievances and Appeals.*	$250 for each mediation or hearing that the PIHP fails to attend as required
9.	Failure to comply with Transition of Care requirements as specified *Section IV.G.3. Care Coordination and Care Transitions for all Members.*	$25 per calendar day, per Member AND The value of the services the PIHP failed to cover during the applicable transition of care period, as determined by the Department.
10.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the PIHP in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the PIHP in connection with the internal plan appeal within the requirements in *Section III.D. 37 Response to State Inquiries and Request for Information*.	$125 per occurrence.
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	$1,250 per occurrence per member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section IV.F.1. Behavioral Health and I/DD Benefits Package.*	$1,250 per standard authorization request $1,875 per expedited authorization request
3.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section IV.H.1. Provider Network.*	$250 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section IV.F.1. Behavioral Health and I/DD Benefits Package.*	$625 per occurrence
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination Policy as required by *Section IV.G.2. Tailored Care Management.*	$62.50 per calendar day

Section VI. First Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure to develop a care management comprehensive assessment, Care Plan, or ISP for a member that includes all required elements as described in the *Section IV.G.2. Tailored Care Management* (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	$125 per deficient/missing care management comprehensive assessment or plan
3.	Failure to adhere to the quarterly minimum contact requirements for a Member's acuity tier as described in *Section IV.G. Care Management and Care Coordination.*	$62.50 per contact not provided per Member (i.e., failure to have two of the required contacts for a Member would result in a $125 payment)
4.	Reserved.	
5.	Failure to comply with minimum care coordination requirements for members with a BH transitional care need as described in *Section IV.G. Care Management and Care Coordination.*	$62.50 per occurrence per Member
6.	Failure to comply with federal conflict-free case management requirements for Members enrolled in the Innovations Waiver.	$125 per occurrence per Member
7.	Failure to complete outreach to all Members in foster care/adoption assistance and former foster youth within twenty-one (21) days of PIHP launch, as described in *Section IV.G. Care Management and Care Coordination.*	$500 per occurrence
8.	Failure to schedule and attend meetings with County Child Welfare Workers for Members involved in the child welfare system, as described in *Section IV.G Care Management and Care Coordination.*	$500 per occurrence
E. Providers		
1.	Failure to update online and printed provider directory with accurate provider information as required by *Section IV.H.2. Provider Network Management.*	$250 per confirmed incident
2.	Failure to report notice of provider termination from participation in the PIHP's provider network (includes terminations initiated by the provider or by the PIHP) to the Department or to the affected Members within the timeframes required by *Section IV.H.2. Provider Network Management.*	$25 per calendar day per Member for failure to timely notify the affected member or Department
3.	Reserved.	
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section IV.H.1. Provider Network.*	$1,250 per calendar day
5.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in *Section IV.H.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$625 per month for failure to meet any of the listed standards, either individually or in combination
6.	Failure to timely submit a PIHP Network Data File that meets the Department's specifications.	$62.50 per calendar day
7.	Failure to maintain accurate provider directory information as required by *Section IV.H.2. Provider Network Management.*	$25 per calendar day per provider

Section VI. First Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
F. Quality and Value		
1.	Failure to submit all required quality measures including audited HEDIS results within the timeframes specified in *Section IV.I.1. Quality Management and Quality Improvement.*	$1,250 per calendar day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section IV.I.1. Quality Management and Quality Improvement.*	$250 per calendar day
3.	Failure to timely submit QAPI to the Department as described in *Section IV.I.1. Quality Management and Quality Improvement.*	$250 per calendar day
G. Claims and Encounter Management		
1.	Failure to timely submit monthly encounter data set certification.	$250 per calendar day
H. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VI. Attachment I. Reporting Requirements.*	$500 per calendar day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VI. Attachment I. Reporting Requirements.*	$250 per calendar day
3.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section IV.K.2. Medical Loss Ratio* and *Section VI. Attachment I. Reporting Requirements.*	$500 per calendar day
4.	Failure to timely and accurately submit financial reports in accordance with *Section VI. Attachment I. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$250 per calendar day
I. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section IV.C. Compliance.*	$1,250 per calendar day that the Department determines the PIHP is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section IV.C. Compliance and Section VI. Attachment I. Reporting Requirements.*	$250 per calendar day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section IV.C.4. Third Party Liability (TPL) and Section VI. Attachment I. Reporting Requirements.*	$62.50 per calendar day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$625 per incident for failure to fully cooperate during an investigation

Section VI. First Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PIHP's own conduct, a provider, or a member.	$62.50 per calendar day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section IV.C. Compliance and Section VI. Attachment I. Reporting Requirements.*	$500 per calendar day
J. Technical Specifications		
1.	Failure by the PIHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$125 per Member per occurrence
2.	Failure by the PIHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$125 per occurrence
3.	Failure by the PIHP to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	$125 per Member per occurrence, not to exceed $2,500,000
K. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$125 per calendar day
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$250 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$125 per calendar day the unapproved agreement or materials are in use
4.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g., drug utilization review program).	$ 5,000 per occurrence per plan or program
5.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	$125 per calendar day for each day the CAP is late, or for each day the PIHP fails to comply with an approved CAP
6.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$125 per occurrence.

Table 2: Metrics, SLAs and Liquidated Damages

Section VI. First Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The PIHP 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 PIHP to its system to trigger enrollment and disenrollment processes.	Daily	$250 per twenty-four (24) hour period Note: Effective one month prior to PIHP.
B. Member Grievances and Appeals					
1.	Member Appeals Resolution - Standard	The PIHP shall resolve at least ninety-eight percent (98%) of PIHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PIHP 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	$2,500 per month
2.	Member Appeals Resolution - Expedited	The PIHP 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 PIHP 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	$2,500 per month
3.	Member Grievance Resolution	The PIHP 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 PIHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$1,250 per month
C. Care Management					
1.	Contracting with AMH+ and CMAs	The PIHP shall contract with 100 percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in the contract (*Section IV.G.2 Tailored Care Management.)*	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the PIHP divided by the total number of certified AMH+ practices and CMAs.	Monthly	$12,500 per month

Section VI. First Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
D. Encounters					
1.	Encounter Data Timeliness	The PIHP shall submit ninety-eight percent (98%) of claims within thirty (30) Calendar Days after payment whether paid or denied.	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	$12.50 per claim per Calendar Day
2.	Encounter Data Accuracy	The PIHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate.	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	$6,250 per month
3.	Encounter Data Reconciliation-	The encounters submitted by the PIHP 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 PIHP.	Monthly	$2,500 per month