Amendment Number 2
Contract #30-2022-007-DHB-#
Medicaid Direct Prepaid Inpatient Health Plan Contract

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

Background:
NC Medicaid Managed Care Medicaid Direct Prepaid Inpatient Health Plan ("Medicaid Direct PIHP") and NC Medicaid Managed Care Behavioral Health Intellectual/Developmental Disability Tailored Plan ("BH I/DD Tailored Plan") were scheduled to launch April 1, 2023. Medicaid Direct Prepaid Inpatient Health Plan shall launch April 1, 2023, while BH I/DD Tailored Plan is scheduled to launch October 1, 2023. Specific services previously scheduled to launch as part of BH I/DD Tailored Plan shall launch as part of the Medicaid Direct Prepaid Inpatient Health Plan until such time BH I/DD Tailored Plan launches.

The purpose of this Amendment is to:

1. Define the requirements and provisions for the services to be provided under this Contract until such time BH I/DD Tailored Plan launches;
2. Modify requirements in *Section III. Contract Term, General Terms and Conditions, Protections, and Attachments;*
3. Modify requirements in *Section IV. Scope of Services*; and
4. Modify *Section VI. Contract Attachments* as specified herein.

The Parties agree as follows:

1. ***Attachment 1: PIHP Supplement Pending BH I/DD Tailored Plan Launch (PIHP Supplement Attachment)*** defines the provisions and requirements for PIHP to supplement Contractual services until such time BH I/DD Tailored Plan launches. The provisions and requirements of *PIHP Supplement Attachment* amend or are in addition to services required under the Contract. The provisions and requirements in *PIHP Supplement Attachment* shall sunset at the launch of BH I/DD Tailored Plan , unless otherwise explicitly incorporated into the Contract.

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

   Specific subsections are modified as stated herein.

   a. *Contract Term, General Terms and Conditions, Protections, and Attachments, B. General Terms and Conditions, 34. Payment Terms, c.* is revised and restated as follows:

      c. Tailored Care Management Payments: The Department will make Tailored Care Management Health Home benefit payments as authorized under the Health Home State Plan Amendment upon the effective date of the Tailored Care Management Health Home SPA. These payments will be made outside capitation under a non-risk payment arrangement.

   b. *Contract Term, General Terms and Conditions, Protections, and Attachments, B. General Terms and Conditions, **45. TERMINATION**, c. Termination for Cause, viii.* is revised and restated as follows:

      viii. Reserved.

c. *Contract Term, General Terms and Conditions, Protections, and Attachments, B. General Terms and Conditions, **49. WAIVER*** is revised and restated as follows:

49. WAIVER: The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance. The Department reserves the right to waive any of the requirements in this Contract by providing written notice of such waiver to Contractor. In order to constitute a waiver, said waiver must be entitled "Waiver of Contract Requirements," list the specific requirement(s) being waived, the timeframe for such waiver, and be signed and dated by the Deputy Secretary for the Division of Health Benefits. For avoidance of doubt or dispute, there shall be no tacit, de facto, verbal, informal, or written waivers signed by anyone other than a Deputy Secretary for the Division of Health Benefits. Without such explicit written and signed "Waiver of Contract Requirements" document, the waiver is not effective.

3. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

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

a. The PIHP shall implement the community crisis services plan as defined in N.C. General Statute § 122c-202.2.

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

vii. PIHP shall cover all services received during an emergency room visit, including all professional services, pharmacy, x-ray and lab services that are directly related to evaluation/treatment of a MH/DD/SA diagnosis.

c. *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* is revised to add the following:

8. During the period up to the effective date of the Health Home SPA, PIHP shall contract with AMH+ practices and CMAs for its administrative care coordination function to conduct Tailored Care Management for a portion of members, as specified in *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.*
9. After the effective date of the Health Home SPA, PIHP shall contract with AMH+ practices and CMAs to provide the Tailored Care Management Health Home State Plan benefit, *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.*

d. *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 (including members participating in EBCI Tribal Option);
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 obtaining Child Assertive Community Treatment (Child ACT);
7. Members obtaining Critical Time Intervention;
8. Members receiving services through SNFs for more than ninety (90) Calendar Days;
9. Members participating in Care Management for At-Risk Children; and
10. Members receiving any approved ILOs that are deemed duplicative through the Department's ILOS approval process.

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

ii. Duplicative services with Tailored Care Management will be allowed during transition prior to the effective date of the Tailored Care Management Health Home Authority, currently planned for July 1, 2023.

1. Until the effective date of the Tailored Care Management Health Home Authority, if a member contacts the PIHP, the PIHP shall support members who are currently enrolled in a duplicative PIHP service select a Tailored Care Management provider (if the member is otherwise eligible for Tailored Care Management services).
2. The PIHP shall support the transition of members who will lose eligibility for Tailored Care Management due to the utilization of a duplicative service upon the effective date of the Tailored Care Management Health Home Authority.
3. Members who are receiving care management through the Department's statewide PCCMe, EBCI Tribal Option, CMARC, CAP/C, or CAP/DA programs can be offered care coordination to supplement the care management provided by their PCCMe, EBCI Tribal Option, CMARC, CAP/C, CAP/DA, or care manager if needed.
4. Members eligible for Tailored Care Management who are currently receiving care management through the state's statewide PCCMe or through CMARC will be prioritized for a warm hand-off transition into Tailored Care Management prior to the effective date of the Tailored Care Management Health Home Authority.

f. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, e. Priority Populations for Engagement into Tailored Care Management, i.* is revised to add the following:

5. Members receiving 1915(b)(3) services.

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

iv. 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.

1. Upon launch of the PIHP program, the Department will require the PIHP to demonstrate appropriate management of Tailored Care Management assignment, as defined in the Department's Tailored Care Management Auto Assignment Requirements Policy. The PIHP shall not be required to assign Member's within twenty-four (24) hours until the PIHP has demonstrated adherence to the Tailored Care Management assignment algorithm for at least thirty (30) Calendar Days.

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

viii. 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, former foster youth receiving TCL services or on the Innovations Waiver, must be defaulted to PIHP-based care management. 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.

i. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment, x., 1.* is revised and restated as follows:

1. PIHP shall monitor care management assignment to ensure that AMH+ practices and CMAs do not select members of their panel based on acuity tier. 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.

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

xv. After the initial launch of the Medicaid Direct Prepaid Inpatient Health Plan, on an ongoing basis PIHP shall complete Tailored Care Management assignment and send the TCM insert within fourteen (14) Calendar Days of a member assignment being accepted by NC FAST. In the event an existing member is re-assigned to a new Tailored Care Management Entity, PIHP shall send a notice containing at least the member's new assignment information.

k. *Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment, xvi. is deleted and reserved as follows:*

xvi. Reserved.

l. *Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, h. Coordination with County Child Welfare Workers for Members involved in the Child Welfare System Engaged in Tailored Care Management v.* is revised and restated as follows:

v. PIHP shall require the assigned organization providing Tailored Care Management to contact the County Child Welfare Worker within one (1) Business Day when any of the following occur, to the extent that information is available, and take necessary measures to ensure coordination of care:
   1. Member is admitted to an inpatient level of care;
   2. Member visits an ED;
   3. Member is admitted to an institutional level of care or other congregate setting;

4. Member experiences a behavioral crisis;
5. Member experiences a disruption in school enrollment (e.g., Member is expelled or is required to change schools);
6. Member becomes involved with the justice system; or
7. Member is boarding in County DSS Office or other location awaiting access to medically necessary behavioral health treatment.

m. *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, iv. Care Management Staff Qualifications, 1., i.* is revised and restated as follows:

i. Care Managers serving all enrollees must have the following qualifications:
   a. Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 Waiver Rules 10A NCAC 27G.0104 and 10A NCAC 28A.0102 related to the experience requirement for Qualified Professionals.
   b. *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, i.* is revised and restated as follows:
      i. PIHP shall ensure that each care manager across AMH+ practices, CMAs and the PIHP is supervised by a supervising care manager. One (1) supervising care manager shall not oversee more than eight (8) care managers with exceptions for extenuating circumstances for no longer than three (3) months.

n. *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, xiii.* is revised and restated as follows:

xiii. PIHP shall ensure that care managers must complete the identified core training modules before being deployed to serve members; care managers must complete the remaining training modules within ninety (90) Calendar Days of being deployed to serve members.
   1. The core modules include:
      a. PIHP eligibility criteria, services available through PIHPs, 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.
      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.
   2. 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 April 1, 2023 launch.
   3. The PIHP or designated vendor shall provide training to its Network providers about Tailored Care Management.
   4. PIHP shall not require care managers, care manager extenders, and supervisors working in multiple Medicaid Direct Prepaid Inpatient Health Plan regions 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 initial training in the region where they serve the most enrollees.
   5. PIHP may require care managers and supervisors to complete additional training, beyond the required domains, specific to PIHP's catchment area or the populations they serve.
   6. The Department will provide guidance in the TCM Provider Manual on care management training requirements, including refresher courses.

o. *Section IV. Scope of Services, G. Care Management and Care Coordination, 4. Care Coordination for Members with a BH Transitional Care Need, e. Care Coordination Functions for Members with a BH Transitional Care Need, i., 3.* is revised and restated as follows:

3. Have a care manager make best efforts to contact the member during their stay in an inpatient psychiatric unit or hospital, Facility-Based Crisis, general hospital unit, or nursing facility and make best effort to contact the member on the day of discharge.

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

13. Care Management for High-Risk Pregnancies (CMHRP) Requirements
    a. PIHP shall work with LHDs for the provision of CMHRP to high-risk pregnant women who are PIHP members as follows:
        i. For TCM eligible Members, PIHP shall identify high-risk pregnancies for CMHRP through one or more of the following mechanisms:
            1. Standardized risk screening tool conducted by providers;
            2. Risk stratification by the PIHP; and
            3. Direct referral by providers, members, or families.
        ii. PIHP shall make best efforts to engage TCM eligible members who are participating in CMHRP into Tailored Care Management and shall assign them to care management according to *Section IV.G.2.f. Tailored Care Management Assignment*. Care managers providing Tailored Care Management will address other needs that are not included in the CMHRP model. A member can receive CMHRP and Tailored Care Management simultaneously.
        iii. For women enrolled in CMHRP as well as Tailored Care Management simultaneously, PIHP shall be responsible for ensuring that the assigned organization providing Tailored Care Management coordinates with LHD care managers to ensure all the members' needs are met, pertinent information is shared, and services are not duplicated between the two programs.
    b. PIHP must participate in Department-led meetings involving the CMHRP program, including requiring attendance by appropriate clinical and operational leadership at meetings.

q. *Section 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, i.-ii*. is revised and restated as follows:

i. Prior to the effective date of the Tailored Care Management Health Home State Plan Amendment, PIHP shall pay AMH+ practices or CMAs the Tailored Care Management monthly rate established by Department for any month in which an enrollee is assigned to the AMH+/CMA and the AMH+/CMA delivers at least one (1) care management contact for that enrollee. Department will publish the established monthly Tailored Care Management rate through the Capitation Rate books. This payment is for delegated non-benefit care coordination functions and is not a care management service. 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.

ii. Beginning on the effective date of the Health Home SPA, 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. 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. 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.

r. *Section IV. Scope of Services, H. Providers, 4. Provider Payments* is revised to add the following:

t. Electronic Visit Verification (EVV) Payments

i. The PIHP shall maintain increased reimbursement from February 1, 2023 to providers subject to EVV requirements by an amount that is no less than ten (10) percent of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic. This uniform percentage increase shall be in addition to required rate increases related to Direct Care Worker wage initiatives defined below.

ii. This reimbursement rate increase applies to the following services:

1. TBI Personal Care;
2. TBI Life Skills Training;
3. TBI In-home Intensive;
4. Innovations Community Living & Supports;
5. Innovations Supported Living Periodic;
6. 1915(b)(3) In-home Skill Building; and
7. 1915(b)(3) Individual Support/Personal Care.

iii. The following codes/modifiers related to live-in caregivers are excluded from EVV and thus not part of the directed payment:

1. T2012 and T2012 HQ; and
2. T2012 GC and T2012 GC HQ.

s. *Section IV. G. Care Management and Care Coordination, 7. Other Care Management Programs, a. High-fidelity Wraparound, ii. Eligibility and Assignment to High-Fidelity Wraparound, 1.* is deleted and reserved as follows:

1. Reserved.

t. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, f. System Standards, iii.* is revised and restated as follows:

iii. 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). PIHP shall implement this capability for provider use no later than September 1, 2023. If an extension is needed, PIHP may submit a request to Department's Contract Administrator for Day-to-Day Activities.

u. Se*ction IV. Scope of Services, K. Financial Requirements, 1. Capitation Payments, e.* is deleted and reserved as follows:

e. Reserved.

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

2. Medical Loss Ratio

a. The Medical Loss Ratio (MLR) standards are to ensure PIHP is directing a sufficient portion of the capitation payments received from Department to services and activities that improve health in alignment with Department's program goals and objectives.

b. PIHP shall calculate and report aggregate MLR for the rating period on two (2) bases as follows:
   i. 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, 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 PIHP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of 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 PIHP's CMS-defined MLR for a MLR reporting year shall equal PIHP's adjusted premium revenue. The adjusted premium revenue shall be defined as PIHP's premium revenue minus PIHP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).
   ii. PIHP shall calculate Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.
      1. PIHP shall report the Department-defined MLR for the entire April 1, 2023 through June 30, 2024 rating period.
   iii. The numerator of Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments: 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 Department's Quality Strategy and meet the following conditions:
      1. Meet standards established in 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 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. PIHP is prohibited from including in 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 Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR.
c. The following requirements apply to both the CMS-defined MLR and Department-defined MLR:
   i. PIHP's classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity, shall be subject to Department review and approval.
   ii. PIHP shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:
      1. Interest or penalty payments to providers for failure to meet prompt payment standards;
      2. Fines and liquidated damages assessed by Department or other regulatory authorities;
      3. Rebates paid to Department if PIHP exceeds the minimum MLR threshold for a prior year;
      4. Voluntary contributions to health-related resources made in lieu of rebates paid to Department if PIHP exceeds the minimum MLR threshold for a prior year; and
      5. PIHP shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations.

iii. PIHP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.
iv. 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.
v. All Tailored Care Management revenue received outside of capitation shall be excluded from the denominator of both the CMS-defined MLR and Department-defined MLR.
vi. PIHP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by Department.
vii. Care Coordination expenses included in the numerator of the MLR shall not exceed the combined expenditures for Care Coordination and Tailored Care Management less Tailored Care Management revenue received outside of capitation.

d. If PIHP's Department-defined MLR is less than the minimum MLR threshold, PIHP shall do one (1) of the following:
i. Remit to Department a rebate equal to the denominator of Department-defined MLR, multiplied by the difference between the minimum MLR threshold and Department defined MLR;
ii. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources, the remaining portion to a rebate to Department, with amounts for each PIHP subject to review and approval by Department; or
iii. Contribute to initiatives that advance public health and Health Equity in alignment with Department's Quality Strategy, subject to approval by Department.

e. The minimum MLR threshold for PIHP shall be eighty-five percent (85%).
f. PIHP must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports in accordance with 42 C.F.R. § 438.8(n).
g. PIHP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to PIHP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year or within thirty (30) Calendar Days of being requested by PIHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).
h. In any instance where Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to Department, PIHP shall:
i. Re-calculate the MLR for all MLR reporting years affected by the change, and
ii. Submit a new MLR report meeting the applicable requirements in accordance with 42 C.F.R. § 438.8(m); 42 C.F.R. § 438.8(k).

w. *Section IV. Scope of Services, K. Financial Requirements, 4. Risk Corridor* is revised and restated as follows:

4. Risk Corridor
a. A risk corridor arrangement between PIHP and Department will apply to share in gains and losses of PIHP as defined in this section. The Risk Corridor payments to and recoupments from PIHP will be based on a comparison of PIHP's reported Risk Corridor Treatment Ratio ("Reported Treatment Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Treatment Ratio consistent with capitation rate setting and set forth in *Section VII. Medicaid PIHP Rate Book* ("Target Treatment 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 PIHP's Reported Treatment Ratio for the measurement period to a Target Treatment Ratio derived from capitation rate-setting by Department. The Target Treatment 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. PIHP Target Treatment Ratio shall be calculated using the Target Treatment Ratio for each rate cell documented in *Section VII. Medicaid PIHP Rate Book* and weighted by 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 Treatment Ratio numerator shall be 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.
   v. Care Coordination expenses as defined by Department. Care Coordination expenses shall not exceed the combined expenditures for Care Coordination and Tailored Care Management less Tailored Care Management revenue received outside of capitation.

f. PIHP is prohibited from including in the Reported Treatment Ratio numerator the following expenditures:
   i. Reserved.
   ii. Reserved.
   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 Treatment 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 paid outside of capitation. The denominator shall be equal to the Department-defined MLR denominator.

h. PIHP shall calculate the numerator and denominator terms of the Reported Treatment 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. PIHP shall 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 Treatment Ratio is less than the Target Treatment Ratio minus three percent (3%), PIHP shall pay Department eighty percent (80%) of the Reported Treatment Ratio denominator multiplied by the difference between the Target Treatment Ratio minus three percent (3%) and the Reported Treatment Ratio.
   ii. If the Reported Treatment Ratio is greater than the Target Treatment Ratio plus three percent (3%), Department shall pay PIHP eighty percent (80%) of the Reported Treatment Ratio denominator multiplied by the difference of the Reported Treatment Ratio and the Target Treatment Ratio plus three percent (3%).

k. Risk Corridor Settlement and Payments
   i. Department will complete a settlement determination for the Risk Corridor Measurement Period.
   ii. PIHP shall provide the Department with an interim Risk Corridor Treatment Ratio report on a timeline and in a format prescribed by Department.
   iii. PIHP shall provide the Department with a final Risk Corridor Treatment Ratio report on a timeline and in a format prescribed by the Department.
   iv. PIHP shall provide additional information and documentation at the request of Department to support the Risk Corridor Settlement determination.
   v. Department may choose to review or audit any information submitted by PIHP.
   vi. Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, Department will make final decisions about covered costs included in the settlement.
   vii. Department will provide 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 Department to PIHP.
   viii. If the final Risk Corridor Settlement requires PIHP to remit funds to Department, the PIHP must submit remittance to Department within ninety (90) Calendar Days of the date of Department's notification of the final Risk Corridor settlement.
   ix. At the sole discretion of Department, Department may allow 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 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 Department.
   x. To be considered for the in lieu of remittance option, PIHP must submit a proposal to Department for review and approval concurrent with or prior to submission of PIHP's interim Risk Corridor Treatment Ratio report.
   xi. If PIHP has not made a required remittance payment within the final date required by this Section, Department may choose to recover any obligation due from PIHP by offsetting a subsequent monthly capitation payment.
   xii. If the final Risk Corridor Settlement requires Department to make additional payment to PIHP, Department shall initiate payment within ninety (90) Calendar Days after Department's notification of the final Risk Corridor settlement. If PIHP initiates a dispute as described in *Section V. Contract Performance* the deadline for Department to make the additional required payments shall be stayed pending the outcome of the dispute.

x. Se*ction IV. Scope of Services, L. Technical Specifications, 6. Technology Documents, b. Security Documentation, iii. SOC 2 Type II Report, 1., i.* is revised and restated as follows:
   i. The following cycle will be used to allow PIHP the time needed to complete the required operations observation period, and the review and reporting period prior to submission to Department:
      a. December 2023 – September 2024 - Audit Operations Period – 6 to 10 Months – During this period it is anticipated PIHPs are working with their auditors to gather the appropriate information and evidence to generate the final report.

b. October 2024 – November 2024 - Report and Review Period – 2 Months – During this period it is anticipated that PIHP 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. December 1, 2024– The finalized document is due to Department. If PIHP completes the audit with a shorter Audit Operations period, PIHP can submit the document early.

4. Modifications to Section VI. Contract Attachments

Specific subsection is modified as stated herein.

a. *Section VI. Attachment A. PIHP Organization Roles and Positions* is revised and restated as *Section VI. First Revised and Restated Attachment A. PIHP Organization Roles and Positions*, and attached to this Amendment as Attachment 2.

b. *Section VI. First Revised and Restated Attachment I. Reporting Requirements* is revised and restated as *Section VI. Second Revised and Restated Attachment I. Reporting Requirements,* and attached to this Amendment as Attachment 3.

c. *Section VI. First Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages* is revised and restated as *Section VI. Second Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages,* and attached to this Amendment as Attachment 4.

5. Effective Date: This Amendment is effective April 1, 2023, subject to approval by CMS.

6. 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

Attachment 1: PIHP Supplement Pending BH I/DD Tailored Plan Launch

This *Attachment 1: PIHP Supplement Pending BH I/DD Tailored Plan Launch* ("PIHP Supplement Attachment") defines the provisions and requirements for PIHP to supplement Contractual services until such time BH I/DD Tailored Plan launches. The provisions and requirements of this *PIHP Supplement Attachment* are in addition to services required under the Contract, with this *PIHP Supplement Attachment* to sunset at the launch of BH I/DD Tailored Plan launch, unless otherwise explicitly incorporated into the Contract.

I. Definitions: Terms defined in *Section II. Definitions and Abbreviations, A. Definitions* of the Contract used in this Amendment have the same meaning as stated in *Section II. Definitions and Abbreviations, A. Definitions* of the Contract unless expressly stated otherwise herein.

II. Financial and Clinical Records: Financial records and clinical records for the Innovations and TBI waivers shall be maintained by PIHP in the manner prescribed in the clinical coverage policies for the Innovations and TBI waivers. In the absence of a policy, PIHP shall follow the requirements of the Contract's Record Retention term.

III. Scope of Services

1. PIHP Eligible Populations to enroll in Medicaid Direct PIHP
    a. The following populations, also referred to as the Tailored Plan eligible population pursuant to N.C. Gen. Stat. § 108D-40(a)(12), shall be enrolled in Medicaid Direct PIHP:
        i. Individuals with a serious emotional disturbance (SED) or a diagnosis of severe substance use disorder (SUD) or traumatic brain injury (TBI).
        ii. Individuals with a developmental disability as defined in N.C. Gen. Stat. § 122C-3(12a).
        iii. Individuals with a mental illness diagnosis who also meet any of the following criteria:
            1) Individuals with serious mental illness (SMI) or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between the Department and the United States Department of Justice, including individuals enrolled in and served under the Transitions to Community Living (TCL) settlement agreement.
            2) Individuals with two (2) or more psychiatric hospitalizations or readmissions within the prior eighteen (18) months.
            3) Individuals who have had two (2) or more visits to the emergency department for a psychiatric problem within the prior eighteen (18) months and are assessed by the Department as eligible for PIHP.
            4) Individuals known to the Department or an LME/MCO to have had one (1) or more involuntary treatment episodes within the prior eighteen (18) months.
        iv. Individuals who, regardless of diagnosis, meet any of the following criteria:
            1) Individuals who have had two (2) or more episodes using BH crisis services within the prior eighteen (18) months and are assessed by the Department .
            2) Individuals receiving any of the BH, I/DD, or TBI services that are covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered by a Standard Plan in accordance with N.C. Gen. Stat. § 108D-35(1).
            3) Individuals who are receiving or need to be receiving BH, I/DD, or TBI services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
            4) Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina.
            5) Children aged zero (0) to three (3) years old with, or at risk for, developmental delay or disability.

6) Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department.

2. Innovations and TBI Services:
   a. PIHP shall provide 1915(c) Innovation Waiver and TBI services to the Tailored Plan eligible population until such time the BH I/DD Tailored Plan Program Launches.
   b. Department will allocate a specific number of Innovations and TBI waiver slots to each PIHP. PIHP shall manage access to its allotted waiver slots, including reserved capacity slots except for Military Transfers, and maintain a Registry of Unmet Needs (waiting list) for members who are determined eligible for waiver funding but for whom funding is not available at the time of their waiver eligibility determination. PIHP shall report on the status of the use of waiver slots and reserved capacity as required by the Department.
   c. Covered Services:
      i. PIHP shall cover Innovations Waiver services identified in *Table 1: Innovation Waiver Services* contingent on CMS approval of 1915(c) Waiver renewals and authorization of funding by the General Assembly.
      ii. PIHP shall cover TBI Waiver services identified in *Table 2: TBI Waiver Services* contingent on CMS approval of 1915(c) Waiver renewals and authorization of funding by the General Assembly. This subsection only applies to those PIHPs with TBI waiver members.

Table 1: PIHP Supplement Attachment Innovations Waiver Services[1]	
• Assistive Technology Equipment and Supplies • Community Living and Support • Community Navigator[2] • Community Networking • Community Transition • Crisis Services • Day Supports • Financial Support Services • Home Modifications • Individual Goods and Services	• Natural Supports Education • Residential Supports • Respite • Supported Employment • Specialized Consultation • Supported Living • Supported Living - Periodic • Supported Living – Transition • Vehicle Adaptations

Table 2: PIHP Supplement Attachment TBI Waiver Services[3]	
• Adult Day Health • Assistive Technology • Cognitive Rehabilitation • Community Networking • Community Transition • Crisis Support Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education	• Occupational Therapy • Personal Care • Physical Therapy • Remote Supports • Residential Supports • Respite • Resource Facilitation • Speech Language Therapy • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

[1] Only Medicaid Direct Prepaid Inpatient Health Plan members who are enrolled in the Innovations waiver will have access to these services.
[2] Community Navigator will continue for people who are self-directing.
[3] Only Medicaid Direct Prepaid Inpatient Health Plan members who are enrolled in the TBI waiver will have access to these services.

d. UM policy for Innovations and TBI waiver services
    i. Innovations waiver services
        1) PIHP shall use the NC Innovations level of care assessment tool to determine whether a Member meets the level of care required by the Innovations Waiver.
        2) PIHP shall utilize a NC Medicaid-approved template to notify Members enrolled in the Innovations Waiver of the results of any new Supports Intensity Scale® (SIS®) evaluation and to inform Members in writing of the opportunity and process for:
            a) Raising concerns regarding SIS® evaluations and results, and
            b) Filing a Grievance regarding SIS® evaluations and results.
        3) The process for raising concerns shall include an opportunity to discuss the results of the SIS® evaluation with PIHP and the potential for the results to be adjusted if it is determined, that the particular needs of the individual were not accurately captured.
        4) The failure to request a Grievance shall not waive the Innovations Waiver Member's ability to argue that the results of the SIS® evaluation are incorrect in requesting of services, or during reconsideration review or the State Fair Hearing.
        5) PIHP shall ensure that the SIS® is used to guide the development of the ISP, and that the results of the SIS®, or any other similar evaluation, are not the sole basis for limiting the services requested or approved. PIHP may use the SIS® in conjunction with other information to reduce or deny requested services.
            a) PIHP shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations Waiver Member and that such desires are reflected in the Innovations Waiver member's ISP, 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).
                i) The Member's care manager based in a PIHP, AMH+ or CMA shall discuss with the Member the duration of the services expected by the Member and shall ensure that proposed ISP request authorization for each service at the duration requested by the member during the ISP plan year.
                ii) The Member's care manager shall assist the Member in developing an ISP and shall explain options regarding the services available to the member.
            b) PIHP shall inform Innovations Waiver Members that they may make a new request for services at any time by requesting an updated ISP.
            c) Care Managers based in a PIHP, AMH+ or CMA may not exercise prior authorization authority over the ISP.
            d) PIHP shall issue prior authorizations for all services covered under the Innovations Waiver according to the requirements set forth in the service definitions that will be established by the Department.
            e) If PIHP authorizes a requested service for a duration less than the duration requested in the ISP, PIHP shall provide written notice with appeal rights and clinical reasons for the decision at the time of the limited authorization.
            f) If PIHP denies a request for authorization of services by a member, in whole or in part, or authorizes a requested service in a limited manner, including the type, level, or duration of service, PIHP shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 CFR § 438.404. i. An Appeal filed by a member must not prevent any authorized services from being provided pending the outcome of the Appeal.

g) PIHP must not prevent the member from making a new request for services during a pending Appeal.

h) 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. 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.

i) PIHP shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations waiver member and that such desires are reflected in the Innovations waiver member's ISP, including the desired type, amount, and duration of services.

j) PIHP shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to the Innovations waivers and other trainings relevant to due process procedures, whether related to the waiver or otherwise.

k) PIHP may terminate a Member from participation in the Innovations Waiver based upon the following circumstances:

i) The Member's or Member's personal representative's fails to comply with the requirements set forth in the Innovations Waiver as approved by CMS;

ii) The member no longer meets the Level of Care criteria stipulated in the Innovations Waiver; or

iii) For other reasons explicitly authorized in the Innovations Waiver approved by CMS.

l) Prior to the termination of a member from the Innovations Waiver, the PIHP must notify the Department of its decision. Termination of Innovations Waiver participation is considered an adverse benefit determination.

ii. TBI waiver services

1) PIHP shall ensure that the TBI waiver level of care tool is used to determine whether a member meets the level of care required for the TBI waiver.

2) PIHP shall ensure that any request for authorization of services is consistent with and incorporates the desires of the TBI waiver member and that such desires are reflected in the TBI waiver member's ISP, 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).

a) The member's care manager based in a PIHP, AMH+ or CMA shall discuss with the member the duration of the services expected by the member and shall ensure that proposed ISP request authorization for each service at the duration requested by the member during the contract year.

b) The member's care manager based in a PIHP, AMH+ or CMA shall assist the member in developing an ISP and shall explain options regarding the services available to the member.

3) PIHP shall inform TBI waiver members that they may make a new request for services at any time by requesting an updated ISP.

4) Care managers based in a PIHP, AMH+ or CMA may not exercise prior authorization authority over the ISP.

5) PIHP shall issue prior authorizations for all BH and I/DD services covered under the 1915(c) waivers and any forthcoming 1915(i) SPAs according to the requirements set forth in the service definitions that will be established by the Department.

6) PIHP may act to terminate a member from participation in the TBI waiver based upon the following circumstances:
    a) The member's or member's personal representative's failure to comply with the requirements set forth in the Innovations or TBI waiver approved by CMS
    b) The member no longer meets the Level of Care criteria stipulated in the Innovations or TBI Waiver.
    c) For other reasons explicitly authorized in the Innovations or TBI waivers approved by CMS.
7) Prior to the termination of a member from the TBI waiver, PIHP must discuss the termination with Department. Termination of Innovations or TBI waiver participation is considered an adverse benefit determination.
8) This subsection only applies to those PIHPs with TBI waiver members.

e. Engagement and Outreach with Innovations and TBI Waiver Members
    i. PIHP shall develop stakeholder group(s) consisting of Innovations Waiver and TBI waiver members, families, advocates, and providers to provide recommendations regarding implementation and operation of Innovations Waiver services and policies.
    ii. PIHP shall meet with this stakeholder group(s) at least on a quarterly basis. Meetings may be virtual, in-person, or hybrid.
    iii. PIHP shall keep meeting minutes and attendance records for each of these stakeholder meetings. PIHP shall make these records available for review by Department and shall report on these efforts during the regular sessions between PIHP and Department. These records should be submitted on a regular basis as defined by Department, with a quarterly minimum.
f. Electronic Verification System Requirements
    i. PIHP shall ensure that utilization of an EVV system for Innovations waiver services, and TBI waiver services is in effect by PIHP launch.
g. Tailored Care Management for Innovations and TBI Waiver Members
    i. PIHP shall enroll and disenroll Innovation and TBI Waiver Members eligible for Tailored Care Management into Tailored Care Management as required in *Section IV.G.2. Tailored Care Management* of the Contract.
    ii. PIHP shall auto-enroll new members who obtain an Innovations and TBI Waiver slot after PIHP launch into Tailored Care Management if they are not already enrolled in Tailored Care Management. 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.
    iii. PIHP must auto-enroll all current Innovations and TBI Waiver enrollees in Tailored Care Management.
        1) Innovations and TBI Waiver enrollees may opt out of Tailored Care Management.
        2) Innovations and TBI 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* of the Contract and Innovations and TBI Waiver care coordination.
    iv. In cases where a member enrolled in the Innovations or TBI Waiver opts out of Tailored Care Management, PIHP must provide the care coordination services as stipulated by the Innovations or TBI Waiver.
    v. Tailored Care Management Assignment
        1) PIHP shall ensure that all eligible Members enrolled in the Innovations and TBI Waiver have a choice of organization where they obtain Tailored Care Management.
        2) PIHP shall consider the following factors when assigning each Member enrolled in the Innovations and TBI Waiver to care management at an AMH+ practice or a CMA, or at the PIHP level:

a) If the member enrolled in the Innovations or TBI 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* of the Contract and is employed by the member's PIHP or in PIHP's network, PIHP must give the member the option of choosing their previous care coordinator as their Tailored Care Management care manager, to the extent possible.

b) PIHP shall assign members enrolled in the Innovations or TBI 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). 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) PIHP shall provide written notification to members regarding requirements for conflict-free case management, including that:

a) Members are entitled to choice in the organization where they obtain Tailored Care Management;

b) Members are entitled to choice in their 1915(c) or 1915(i) service providers; and

c) 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.

d) PIHP must submit a draft of this notice to the Department for approval.

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

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

vii. Additional Tailored Care Management Requirements for Members Enrolled in the Innovations and TBI Waiver

1) For members who were enrolled in the Innovations or TBI Waivers prior to PIHP launch and engage in Tailored Care Management:

a) If the member's ISP annual update is in the first six (6) months of Year 1 of PIHP launch, PIHP shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment prior to completing the ISP.

b) If the member's annual update is in the second half of Year 1 of PIHP launch, 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* of the Contract. 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.

c) 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.

d) 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.

e) 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 or TBI Waivers, 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):
    a) The contact requirements found in the 1915(c) Waiver, or
    b) The contacts noted in *Section IV.G.2. Tailored Care Management* of the Contract.
3) For Innovations and TBI Waiver enrollees, 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.

viii. For Innovations and TBI Waiver members engaged in Tailored Care Management, 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* of the Contract. 42 C.F.R. § 441.301(c)(1)(vi).

ix. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waivers
1) In cases where a member enrolled in the Innovations or TBI Waivers opts out of Tailored Care Management, PIHP must provide the Innovations or TBI 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).
    a) PIHP shall ensure that Innovations and TBI Waiver care coordination services are performed by a care manager meeting the following qualifications:
        i) Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area;
        ii) Two (2) years of experience working directly with individuals with I/DD; and
        iii) 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) Department will not make a Tailored Care Management payment to PIHP for members who opt out of Tailored Care Management, as described in *Section IV.H.4. Provider Payments* of the Contract.
3) For all members enrolled in the Innovations or TBI Waivers, regardless of whether they engage in Tailored Care Management, PIHP shall ensure that Waiver care coordination includes:
    a) Guiding the development and submission of the ISP, based on assessed need and living arrangements, at least annually:
        i) 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.
        ii) If applicable, PIHP shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the ISP to the PIHP.
        iii) PIHP shall review ISP for Waiver compliance, medical necessity, and the member's health and safety needs.
        iv) 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.
        v) PIHP shall ensure that Waiver services begin within forty-five (45) Calendar Days of ISP approval.
        vi) 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.

b) Monitoring and contact requirements found in the 1915(c) Waiver.
c) Explaining the individual budgeting tool, the service authorization process and the mechanisms available to the member/legally responsible person (LRP) to modify their budget.
d) 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.
e) Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal.
f) 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.
g) Informing the member/LRP of the option to participate in individual-directed/family-directed supports.
h) Assisting in the appointment of the representative for self-direction, as needed.
i) Assessing the employer of record, managing employer and representative, if applicable, to determine the areas of support needed to self-direct services.
j) Promoting the delivery of services and supports in the most clinically appropriate, integrated setting.
k) Completing annual reassessment of the member's level of care.
l) Ensuring that the member/LRP completes the Freedom of Choice statement annually.
m) 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.
n) Providing timely notification to PIHP utilization management of updates to the level of care determination and timely processing of updates to the ISP.
o) 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.
p) Monitoring of service delivery to verify that:

i) 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.
ii) Services are furnished in accordance with the ISP.
iii) Member is offered a choice of Waiver service providers.
iv) Member has access to services and services meet the member's needs.
v) 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.
vi) Services utilized do not exceed authorization.
vii) Member is satisfied with the services being rendered.
viii) Services are compliant with HCBS final rule as applicable.

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

x. In-Reach and Transition from Institutional Settings: 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. In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State: 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 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.

3. Risk Reserves

a. PIHP shall maintain a restricted risk reserve account with a federally guaranteed financial institution licensed to do business in the State of North Carolina or the North Carolina Capital Management Trust. PIHP shall maintain the restricted risk reserve account consistent with N.C. G. S. § 159-30, either as a depository account pursuant to N.C. G. S. § 159-30(b) and (b1), or as an investment account pursuant to N.C. G. S. § 159-30(c). Investment accounts shall have a term of twelve (12) months or less. For purposes of this Section, the usual annualized cost of this Contract is reflected on Schedule B (Medicaid Risk Reserve) of the LME/MCO Financial Report. The following requirements apply:

i. Required Minimum Balance: PIHP shall, on a monthly basis, deposit into the restricted risk reserve account a minimum amount equal to two (2%) of the capitation payments received from Department until the amount in the risk reserve account equals twelve and one-half percent (12.5%) of the usual annualized cost of this Contract. After PIHP's risk reserve account equals twelve and one-half percent (12.5%), PIHP shall deposit into the restricted risk reserve account a minimum amount equal to one and one-half (1.5%) of the capitation payments received from Department until the amount in the risk reserve account equals fifteen percent (15%) of the usual annualized cost of this Contract. Deposits shall be made within five (5) Business Days of receiving the monthly capitation payment. PIHP shall notify Department in writing when PIHP determines that its risk reserve account equals fifteen percent (15%) of the usual annualized cost of this Contract. Upon such notification, Department shall have ten (10) Business Days to verify and notify PIHP that it shall no longer be required to deposit into the restricted risk reserve account, on a monthly basis, a minimum amount equal to one and one-half percent (1.5%) of the capitation payments received from Department. If Department fails to notify PIHP within ten (10) Business Days, PIHP will no longer be required to make a deposit.

ii. The restrictions on use and the requirement that PIHP first obtain Department's written approval for withdrawals or disbursement described in this Section shall not apply to any amount of the risk reserve account that exceeds fifteen percent (15%) of the annualized cost of this Contract, as reflected in the Financial Reporting Guide Template.

iii. Withdrawal or disbursement notifications: PIHP shall first obtain Department's prior written approval for any withdrawals or disbursements. Department will provide a response within seven (7) Calendar Days of the request. Expenditures shall conform to the requirements for the expenditure of funds under Section 1915(b) of the Social Security Act (42 U.S.C. 1396b). The restricted risk reserve shall not be used to pay for items that are not directly related to the provision of services.

iv. Replenishing restricted risk reserve account for withdrawals/disbursements: If the risk reserve account drops below the minimum balance required, as a result of withdrawals or disbursements specified in *Section 3. a. iii*. above, PIHP shall deposit on a monthly basis into the restricted risk reserve account an amount not less than fifteen percent (15%) of the monthly capitation payments received from Department until the amount of the withdrawal or disbursement is replenished. PIHP may make contributions to the restricted risk reserve account in excess of the minimum balance required in *Section 3. a. iii*. above.

v. The restrictions on use, and the requirement that PIHP first obtain Department's written approval for withdrawals or disbursements described in this Section shall not apply to any amount of the risk reserve account that exceeds fifteen percent (15%) of the annualized cost of this Contract as reflected on Schedule B (Medicaid Risk Reserve) of the PIHP Financial Report.

IV. Network Adequacy Standards for Innovations and TBI Waiver Services

The following Network Adequacy Standards for Innovations and TBI Waiver Services apply for the duration of this *PIHP Supplement Attachment*.

Table 3: PIHP Supplement Attachment Time/Distance Standards for Innovations and TBI Waiver Services

Reference Number	Service Type	Urban Standard	Rural Standard
1.	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Navigator, 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	
2.	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• *Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment:* ≥ 2 providers of each TBI waiver service within each PIHP Region. • *Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports:* ≥ 1 provider of each TBI waiver service within each PIHP Region. • *Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification*: N/A	

Table 4: PIHP Supplement Attachment Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
1.	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 • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications
2.	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Remote supports • Residential Supports • Resource Facilitation • Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Supported living • Vehicle Modifications

V. Reports

PIHP shall submit to Department the following reports prior to BH I/DD Tailored Plan Launch:

Table 5: PIHP Supplement Attachment Pending BH I/DD Tailored Plan Launch Reports		
PIHP Report Name	**PIHP Report Description**	**Frequency**
1. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver slots and reserved capacity, and list of members on the Registry of Unmet Need (waiting list).	Monthly
2. Financial Reporting Guide Template	Monthly financial reports will be used to monitor the operations of the PIHP including Medicaid and non-Medicaid funding source.	Monthly

VI. Quality Metrics for Medicaid

PIHP is required to report the TBI Waiver Performance Measures identified in this *Section VI*. The quality measures will be reviewed and updated annually. Department will monitor other measures that are not included in the tables below and may engage with PIHP around these performance measures.

Table 6: PIHP Supplement Attachment TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
3.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11

Table 6: PIHP Supplement Attachment TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
6.	Proportion of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
7.	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of Individual Support Plans 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

Table 6: PIHP Supplement Attachment TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of person-centered plans that are completed in accordance with the State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of individuals for whom an annual plan and/or needed update took place	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
17.	Proportion of new waiver beneficiaries receiving services according to their ISP within 45 days of ISP approval	NC DHHS	Annually Fiscal Year	November 1
18.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 3 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
19.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
20.	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1

Table 6: PIHP Supplement Attachment TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
22.	Number and Percent of Actions Taken to Protect the Beneficiary, where indicated	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 3 d. April 1 – June 30	a. February 1 b. May 1 c. August d. November 1
23.	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
24.	Number and Percentage of deaths where required BH I/DD TP 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
25.	Percentage of medication errors 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
26.	Percentage of 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
27.	Percentage of level 2 and 3 incidents reported within required time frames	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 level 2 or 3 incidents where required BH I/DD TP 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
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

Table 6: PIHP Supplement Attachment TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
30.	Percentage of restrictive interventions 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
31.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities	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.	Percent of restrictive interventions used by a trained staff member.	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.	Percent of restrictive interventions that are documented according to state policy.	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.	The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year.	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
35.	The percentage of waiver beneficiaries age 22 and older who had a primary care or preventative care visit during the waiver year	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.	The proportion of claims paid by the PIHP for NC TBI wavier services that have been authorized in the service plan	NC DHHS	Annually Fiscal Year	November 1

VII. Waiver of Contract Requirements

1. PIHP shall not be required to purchase reinsurance as defined in *Section IV.K.3.e. Reinsurance* of the Contract.

2. The requirements stated in *Section IV. Scope of Services, C. Compliance, 4. Third-Party Liability (TPL)* of the Contract shall not apply.

3. The requirements stated in *Section VI. Contract Attachments A-W, Attachment F. First Revised and Restated Required Standard Provisions for PIHP and Provider Contracts* of the Contract shall not apply. PIHP may continue to use their existing provider contracts, and any provisions of this Contract (including but not limited

to *Section VI. Contract Attachments A-W, Attachment F. First Revised and Restated Required Standard Provisions for PIHP and Provider Contracts*) that impose requirements on the provider contracts beyond what is currently existing in those contracts shall not be required until BH I/DD Tailored Plan Launch.

VIII. Termination or Expiration of this *PIHP Supplemental Attachment*: Upon PIHP's receipt of Department's written acknowledgment, which Department shall send in writing to PIHP's Contract Administrator, that PIHP has met all outstanding obligations incurred pursuant to this Contract, the balance of the restricted risk reserve account upon the date of termination or expiration of this Contract shall become the property of PIHP. Notwithstanding the foregoing, the full amount of the restricted risk reserve shall become the property of PIHP as unrestricted operating funds at the expiration of this Contract and the first day of operation of the BH I/DD Tailored Plan contract.

IX. Other Requirements: Unless expressly provided for herein, all other terms and conditions of the Contract, as amended, shall remain in full force and effect.

Attachment 2

Section VI. First Revised and Restated Attachment A. PIHP Organization Roles and Positions

Department requires that PIHP staff the following roles. Personnel described in this section, even if the titles are not the same, may perform functions for both the BH/IDD Tailored Plan Contract and the Medicaid Direct Prepaid Inpatient Health Plan Contract. Compliance with similar provisions in the BH I/DD Tailored Plan Contract will be deemed compliance for this Contract.

Section VI. First Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Supervising Care Managers	These individuals are responsible for overseeing assigned care managers delivering Tailored Care Management and care coordination. These individuals are responsible for reviewing all Care Plans and ISPs for quality control and providing guidance to care managers on how to address Members' complex health and social needs. These individuals are responsible for ensuring fidelity to the Tailored Care Management model.	• Must meet North Carolina Residency requirements. • If serving Members with BH conditions, must hold 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). • Three years of experience providing care management, case management, or care coordination to the population being served. • Supervising care managers serving enrollees with an I/DD or a TBI must have one (1) of the following minimum qualifications: o 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 o A master's degree in a human service field and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; OR o A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI. • If an enrollee is dually diagnosed with a behavioral health condition and an I/DD or a TBI, PIHP and assigned organization providing Tailored Care Management must ensure that the supervising care manager is

Section VI. First Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		qualified to oversee the enrollee's care manager. • The Department will grant a one-time staff exception ('grandfathering') for specified PIHP staff that: o 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). o This exception is based on the staff enrollee possession the required number of years of experience, but not the required degree, degree type or licensure type.
2. Care Managers	These individuals shall be responsible for providing: • Integrated whole-person care management under the Tailored Care Management model, including coordinating across BH, I/DD, TBI, LTSS, and Unmet Health-Related Resource Needs; • Care coordination for Members with a behavioral health transitional care need; and • Care coordination for all Members.	• Must meet North Carolina Residency requirements. • Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 waiver of experience requirement for Qualified Professionals. • For care managers serving enrollees with LTSS needs: o Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. o 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.
3. Full-Time Care Management Housing Specialist(s)	This individual or these individuals act as expert(s) on affordable and supportive housing programs for Members and care managers. This individual or these individuals coordinate with relevant staff at Department or PIHP (e.g., Transition Coordinators and DSOHF staff).	• Must meet North Carolina Residency requirements.
4. Full-Time Transition Supervisor(s)	This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.	• Must meet North Carolina Residency requirements. • Must meet the care manager supervisor qualifications described above and outlined in *Section IV.G. Care Management.* PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.

Section VI. First Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
5. Full-Time Transition Coordinator(s)	This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for: • Individuals who are moving from a state psychiatric hospital to supportive housing; and • individuals moving from a state developmental center or an ACH to a community setting.	• Must meet North Carolina Residency requirements. Transition Coordinators serving individuals with SMI: • Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or • Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. Transition Coordinators serving individuals with I/DD or TBI: • Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD; or • Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. • PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
6. Full-Time Peer Support Specialist(s)	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members with BH diagnoses residing in a state psychiatric hospital or an ACH.	• Must meet North Carolina Residency requirements. • Must have NC Certified Peer Support Specialist Program Certification.
7. Full-Time In-Reach Specialist(s)	This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.	• Must meet North Carolina Residency requirements. • Must hold a Bachelor's degree in a human services field. • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians. • PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
8. System of Care Family Partner(s)	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to PIHP's System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold high school diploma or GED. • Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid services.

Section VI. First Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
9. System of Care Coordinator(s)	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to PIHP's System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold: o a Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; or o a Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems.
10. DSOHF Admission Through Discharge Manager	These individuals are responsible for: • Coordinating and/or performing transition functions and activities described in Section *IV.G. Care Management* for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. Coordinating and/or performing discharge planning functions for PIHP members who are not receiving transition functions and activities described in Section *IV.G. Care Management* DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as PIHP's liaison to ADATCs in the PIHP's region.	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: • Must meet North Carolina Residency requirements. • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: • Must meet North Carolina Residency requirements. • Must hold: o a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or o a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or o hold a Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
11. Member Appeal Coordinator	This individual manages and coordinates member appeals in a timely manner.	• Must meet North Carolina Residency requirements.
12. Member Grievance Coordinator	This individual manages and attempts to resolve Member grievances in a timely manner.	• Must meet North Carolina Residency requirements.

Section VI. First Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
13. Full-Time Member Grievance Staff	These individuals work to resolve Member grievances in accordance with state and federal laws and this Contract.	• For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing grievances.
14. Full-Time Peer Review and/or Member Appeals Staff	These individuals work to resolve Member appeals in accordance with state and federal laws and this Contract.	• Peer reviewers must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals.
15. Full-Time Member Services and Service Line Staff	These individuals coordinate communication with Members	• Must meet North Carolina Residency requirements.
16. Provider Relations and Service Line Staff	These individuals coordinate communications between PIHP and providers.	• Must meet North Carolina Residency requirements.
17. Provider Network Relations Staff	These individuals support the Provider Network Director in network development and management.	• Must meet North Carolina Residency requirements.
18. Provider Grievance Coordinator	This individual manages and resolves provider grievances in a timely manner.	• Must meet North Carolina Residency requirements.
19. Provider Appeal Coordinator	This individual coordinates and manages provider appeals in a timely manner.	• Must meet North Carolina Residency requirements.
20. Full-Time BH/SUD Utilization Management Staff	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing.
21. Full-Time I/DD Utilization Management Staff	These individuals conduct I/DD UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	• Must be a Qualified Intellectual Disability Professional, or Qualified Professional, in the area of Developmental Disabilities as specified in 42 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3.
22. Tribal Provider Contracting Specialist	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must meet North Carolina Residency requirements.
23. Liaison between the Department and the North Carolina Attorney General's MID	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must meet North Carolina Residency requirements.
24. Special Investigations Unit (SIU) Lead	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, criminal

Section VI. First Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		justice, or pre-law, or have at least five (5) years of relevant experience. • Must complete CLEAR training or provide a timeframe as to when it will be complete.
25. Special Investigations Unit (SIU) Staff	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice, or have at least three (3) years of relevant experience.
26. Liaison to the Division of Social Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinated through local DSS offices, and serves as a primary contact to triage and escalate member specific or PIHP questions.	• Must meet North Carolina Residency requirements.
27. Waiver Contract Manager	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1915(i) SPA and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	• Must meet North Carolina Residency requirements. • Minimum of seven (7) years of management experience, preferably in human services

Remainder of This Page Left Intentionally Blank

Attachment 3

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

The following tables detail the reports PIHP must submit to Department.

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

1. Although the Department has indicated the reports that are required, PIHP may suggest additional reports.
2. As part of Readiness Review, PIHP shall submit to Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. PIHP shall submit complete and accurate data required by Department for tracking information on Members obtaining Medicaid in Medicaid Direct 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 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. PIHP shall submit all data on a schedule provided by Department and shall participate in data quality improvement initiatives specified by Department.
5. PIHP shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to Department.
6. PIHP shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to Department.

Section VI. Second 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 sent, and time to distribute Member welcome packets.	Monthly

Section VI. Second 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. Second 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. Second 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
9. Reserved		
10. 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. Second Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
11. 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
12. 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. Second 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
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. Second 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 ten (10) Calendar 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. Second 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. Second 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.		

Attachment 4

Section VI. Second Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages

Table 1: Liquidated Damages for Compliance Issues

Section VI. Second 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

Section VI. Second Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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
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 Department for the timeframe specified by Department. AND $125 per Calendar Day for each day PIHP fails to provide continuation or restoration as required by 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 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 PIHP failed to cover during the applicable transition of care period, as determined by 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

Section VI. Second Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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
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

Section VI. Second Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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.	Reserved.	
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 Department determines 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

Section VI. Second Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to 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

Section VI. Second Revised and Restated Attachment N: Table 1: Liquidated Damages		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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 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. Second 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 (1) month prior to Medicaid Direct PIHP launch.
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

Section VI. Second Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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