Amendment Number 17 (18)
Prepaid Health Plan Services
#30-190029-DHB – PHP Name

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

Background:

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

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

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

a. *Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, A. Definitions* is revised to add the following:

173. **Bonus Pool:** The total amount of unearned funds that may remain following the Department's withhold determination for a performance measure if one or more PHPs do not fully meet the performance targets established for the measure during the applicable performance period.

174. **Healthy Opportunities Pilot Administrative Payment Withhold (Pilot Administrative Payment Withhold):** A set percentage of the PHP's Pilot administrative payment in which the PHP, in partnership with its Tier 3 AMH and CIN Delegated Pilot Care Management Entities, is required to meet specific performance target(s) established by the Department, pursuant to the 1115 Demonstration Waiver, as a condition for receiving the retained portion of the payment. The Pilot Administrative Payment Withhold is not considered a withhold arrangement within the meaning of 42 C.F.R. § 438.6.

175. **Healthy Opportunities Pilot Care Management Payment Withhold (Pilot Care Management Payment Withhold):** A set percentage of the monthly care management payment provided to Tier 3 AMH and CIN Delegated Pilot Care Management Entities for which the entities, in partnership with its PHP(s) and its PHP(s)' other Tier 3 AMH and CIN Delegated Pilot Care Management Entities, are required to meet specific performance

target(s) established by the Department, pursuant to the 1115 Demonstration Waiver, as a condition to receive the retained portion of the payment. The Pilot Care Management Payment Withhold is not considered a withhold arrangement within the meaning of 42 C.F.R. § 438.6.

176. **Healthy Opportunities Pilot Program Withholds (HOP Withholds):** A term used to collectively refer to the Pilot Administrative Payment Withhold and the Pilot Care Management Payment Withhold. HOP Withholds are not considered a withhold arrangement within the meaning of 42 C.F.R. § 438.6.
177. **Loss Limit:** A set percentage of Bonus Pool funds that are excluded from the Bonus Pool and are not available for distribution to a PHP.
178. **Rating Period:** Has the same meaning as described in 42 C.F.R. § 438.2. For purposes of the Contract the rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State fiscal year. Shorter rating periods may apply, as specified in the Contract, but will be contained within the State fiscal year unless otherwise specified by the Department.
179. **Withhold Arrangement:** Has the same meaning as described in 42 C.F.R. § 438.6(a).

b. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. <u>PAYMENT AND REIMBURSEMENT</u>, e. Enhanced Case Management Pilots to Address Unmet Health-Related Needs Payments, also known as the Healthy Opportunities Pilot Payments, ii. Capped Allocation, e) Pilot Administrative Payments*** **is revised and restated in its entirety as follows:**

e) Pilot Administrative Payments

1. The Department shall distribute as part of Contractor's capped allocation Pilot administrative payments for Contractor to retain to cover administrative costs associated with Pilot operations.
2. The Department shall determine the amount of Contractor's Pilot administrative payments, including setting the percentage of the PHP's Pilot Administrative Payment Withhold for each applicable performance period.
3. The Department shall distribute the Pilot administrative payment, except for the PHP's Pilot Administrative Payment Withhold, for each Pilot Service Delivery Period at a frequency as defined in the Department's Healthy Opportunities Pilot Payment Protocol.
4. The Department shall distribute the administrative payments retained as part of the Pilot Administrative Payment Withhold to the PHP only if the PHP, in partnership with its Tier 3 AMH and CIN Delegated Pilot Care Management Entities, meets the performance target(s), as determined by the Department, after the end of the applicable performance period as specified in *Section V.I.6. Healthy Opportunities Pilot Payments*.

c. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT, e. Enhanced Case Management Pilots to Address Unmet Health-Related Needs Payments, also known as the Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payments:*** **is revised and restated in its entirety as follows:**

iii. Pilot Care Management Payments:

a) The Department shall make fixed payments to Contractor and Contractor shall make Pilot care management payments to Designated Pilot Care Management Entities as specified in *Section V.D.4. Provider Payments*. The Department will determine Pilot care management payments and document them in the Department's Healthy Opportunities Pilot Payment Protocol, and the Pilot Care Management Payment Withhold and document them in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide.

b) Pilot Care Management Payment Withhold

1. The Department shall retain the Pilot Care Management Payment Withhold from the fixed Pilot care management payments made to the PHP for Tier 3 AMH and CIN Designated Pilot Care Management Entities in a manner and frequency as specified in *Section V.D.4. Provider Payments.*
2. As necessary, the PHP shall distribute the funds retained as part of the Pilot Care Management Payment Withhold to Tier 3 AMH and CIN Designated Pilot Care Management Entities in accordance with *Section V.D.4. Provider Payments*.

d. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT, e. Enhanced Case Management Pilots to Address Unmet Health-Related Needs Payments, also known as the Healthy Opportunities Pilot Payments, iv. Pilot Value-Based Payments:, b)*** **is revised and restated in its entirety as follows:**

b) As provided in *Section V.I. 6. Healthy Opportunities Pilot Payments*, the Contractor shall be required to participate in the Pilot-specific value-based payment program and will be eligible to receive separate Pilot-specific value-based payments from the Department. Payment will be made after the Department has reviewed documentation of Contractor's performance against targets. The value-based payments made by the Department to Contractor will be subject to adjustments in accordance with the Department's assessment of Contractor's performance against specific targets to be detailed in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.

e. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT, i. Other Managed Care Payment Terms and Conditions:, ii.*** **is revised and restated in its entirety as follows:**

ii. Except as otherwise provided, the Department may apply withholds, monetary sanctions, liquidated damages, or other or adjustments as described in *Section V.D. Provider Payments, Section V.E. Quality Management and Quality Improvement, Section V.I. Financial Requirements*, and *Section VI. Contract Performance* to any payment due to Contractor.

II. Modifications to Section V. Scope of Services of the Contract

Specific subsections are modified as stated herein.

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

i. The PHP shall comply with Department policies as identified and required by the Department, including the following:
   a) Medicaid Managed Care Enrollment Policy
   b) Department Clinical Coverage Policies;
   c) Transition of Care Policy;
   d) Care Management Policy;
   e) Advanced Medical Home Program Policy;
   f) Care Management for High-Risk Pregnancy Policy;
   g) Care Management for At-Risk Children Policy;
   h) Management of Inborn Errors of Metabolism Policy;
   i) Uniform Credentialing and Recredentialing Policy;
   j) NC Non-Emergency Medical Transportation Managed Care Policy;
   k) Advanced Medical Home Provider Manual;
   l) Healthy Opportunities Pilot Care Management Protocol;
   m) Healthy Opportunities Pilot Payment Protocol;
   n) Healthy Opportunities Pilot Transitions of Care Protocol;
   o) Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide;
   p) Managed Care Clinical Supplemental Guidance;
   q) PHP Member Advisory Committee Guidance;
   r) Notice of Adverse Benefit Determination Clearinghouse Upload Instructions~~.~~ and
   s) North Carolina Medicaid Withhold Program Guidance.

b. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, f) Ingredient Costs for Non-340B, 2., iii.*** **is revised and restated in its entirety as follows:**

iii. Reserved.

c. *Section V.C. Benefits and Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, g) Ingredient Costs for 340B* is revised to add the following:

3. 340B Ceiling Rate File
    i. To facilitate compliance and ensure alignment with the reimbursement methodology of 340B drugs defined in the Medicaid State Plan and solely for the purpose of processing 340B NCPDP drug claims, the Department will share the confidential 340B Ceiling Rate File used by the Department in the Medicaid Direct program with the PHP, upon receipt of approval from and to the extent permitted by CMS.
    ii. Effective for dates of service on and after January 1, 2024, the PHP shall reimburse 340B NCPDP claims at Actual Acquisition Cost plus the professional dispensing fee. If the Actual Acquisition Cost exceeds the cost defined in the Department's 340B Ceiling Rate File, the PHP shall reimburse 340B NCPDP claims at the 340B Ceiling Rate plus the professional dispensing fee.
        a. The Department shall provide the 340B Ceiling Rate File to the PHP electronically no less than quarterly.
        b. The PHP shall implement the initial 340B Ceiling Rate File within sixty (60) Calendar Days of receipt of the File from the Department. For any subsequent 340B Ceiling Rate File changes, the PHP shall update their system to apply the changes no more than seven (7) Calendar Days following the PHP's receipt of the 340B Ceiling Rate File from the Department.
    iii. Confidentiality of the 340B Ceiling Rate File
        a. In accordance with Section 1927(b)(3)(D) of the Social Security Act and *Section III.E.2. Confidential Information*, upon receipt of the 340B Ceiling Rate File from the Department, the PHP is required to maintain the confidentiality of the File and may only use the File for the exclusive purpose of facilitating Contractor's compliance with the reimbursement of 340B drugs in accordance with *Section V.B.3. Pharmacy Benefits*.
        b. To the extent that the PHP has contracted with a PBM to assist in the processing of 340B drug claims, the PHP may share the 340B Ceiling Rate File with its PBM for the sole purpose of assisting the PHP with processing 340B drug claims as required by the Contract, if certain conditions are met. To redisclose the 340B File to its PBM, The PHP shall adhere to the following:
            1) The disclosure to the PBM shall be for the sole purpose of assisting the PHP with processing 340B drug claims arising under and as required by the Contract.
            2) Each disclosure of the 340B Ceiling Rate File by the PHP to the PBM is accompanied by the Confidentiality Notice specified in *Section VII. Attachment M.15. 340B Ceiling Rate File Confidentiality Notice*.
            3) Prior to the initial 340B Ceiling Rate File disclosure to the PBM, and annually thereafter, the PHP provides the Department with a written attestation, developed by the Department, attesting to adherence with the conditions established by the Department for sharing the 340B Ceiling Rate File.
    iv. Except as provided in the Contract or as approved by the Department in writing, the PHP shall not disclose, share, modify content, release, or use the 340B Ceiling Rate File for any purpose outside of the processing of 340B drug claims under this Contract.

d. *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments, c)* is revised and restated in its entirety as follows:

c) The PHP shall pay fixed care management payment amounts set by the Department as defined in the Department's Healthy Opportunities Pilot Payment Protocol, including the Pilot Care Management Payment Withhold, if the Department determines that the performance target(s) is met, as defined in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual. Care management payment amounts, including the amount of the Pilot Care Management Payment Withhold, may not be negotiated between the PHP and Designated Pilot Care Management Entities. Once received from the Department, the PHP shall pass on the full amount of care management payments, including any earned amounts that were retained under the Pilot Care Management Payment Withhold as applicable, to Designated Pilot Care Management Entities that participate in the Pilots and serve Pilot enrollees. The PHP cannot retain care management payments.

e. *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot* Payments is revised to add the following:

iii. Pilot Care Management Payment Withhold

a) The Department shall retain one percent (1%) of the monthly fixed Pilot care management payments distributed by the Department to the PHP for its Tier 3 AMH and CIN Designated Pilot Care Management Entities, beginning in Standard Plan Pilot Value-Based Payment Period Three (3) and at a date specified in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide, in accordance with *Section III.D.32. PAYMENT AND REIMBURSEMENT*.

b) Each applicable performance period subject to the Pilot Care Management Payment Withhold shall be defined by the Department in the Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide.

c) The PHP shall have a method to track and reconcile the amount of the Pilot Care Management Withhold that may be owed to each of its Tier 3 AMH and CIN Designated Pilot Care Management Entities at the end of each applicable performance period.

d) Prior to the Department withholding a portion of the Pilot care management payments distributed to the PHP for payment to its Tier 3 AMH and CIN Designated Pilot Care Management Entities pursuant to this Section and *Section III.D.32. PAYMENT AND REIMBURSEMENT*, the Department shall provide the PHP with written notice detailing the performance measure subject to the withhold, the performance period, the percentage of the monthly payment being withheld, and the effective date in which the Department will begin withholding funds. Within fifteen (15) Calendar Days of the receipt of the written notice from the Department, the PHP shall notify its Tier 3 AMH and CIN Delegated Pilot Care Management Entities of the applicable withhold(s), the performance targets and applicable performance period, the percentage of the monthly payment being withheld, and the effective date in which the Department will begin withholding.

e) Performance Targets for Pilot Care Management Payment Withhold

1. For the PHP's Tier 3 AMH and CIN Delegated Pilot Care Management Entities to receive the amounts retained under the Pilot Care Management Payment Withhold, the PHP, in partnership with its Tier 3 AMH and CIN Designated Pilot Care Management Entities, shall meet the performance target(s) during the applicable performance period as defined in the Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.
2. For each identified performance target, the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual shall define the Department's methodology for determining if the target has been met.
3. Following the end of the applicable performance period, the Department shall issue a written Notice of HOP Withhold Determination to the PHP detailing the Department's determination of whether the PHP, in partnership with its Tier 3 AMH and CIN Delegated Pilot Care Management Entities, met the applicable performance target(s) during the performance period. Within thirty (30) Calendar Days of receipt of the Department's Notice of HOP Withhold Determination, the PHP shall notify each of its Tier 3 AMH and CIN Delegated Pilot Care Management Entities of the Department's determination.
4. If the Department determines that the performance target(s) have been met by the end of the applicable performance period, the Department will pay out the amount retained from the fixed Pilot care management payments to the PHP within sixty (60) Calendar Days of the date of the written Notice of HOP Withhold Determination for payment to its Tier 3 AMH and CIN Delegated Care Management Entities. Once received from the Department, the PHP shall distribute the applicable portion of the retained amounts owed to each of its Tier 3 AMH and CIN Delegated Pilot Care Management Entities within sixty (60) Calendar Days of receipt of the funds from the Department.
5. If the Department determines that the performance target(s) have not been met by the end of the applicable performance period, the Department will continue to keep the retained amounts.

f. *Section V.D. Providers 4. Provider Payments, ii.* is revised to make a technical correction to numbering as follows:

ii. Electric Visit Verification System (EVV)

i. Beginning February 1, 2023, the PHP shall increase reimbursement to Home Health Care Services (HHCS) providers subject to EVV requirements by an amount that is no less than ten percent (10%) of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic.

ii. This February 1, 2023, the PHP shall increase reimbursement to Home Health Care Services (HHCS) providers subject to EVV requirements by an amount that is no less than ten percent (10%) of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic:

a) Physical Therapy.
b) Physical Therapy evaluation.

c) Occupational Therapy.
d) Occupational Therapy evaluation.
e) Speech-language Pathology services.
f) Speech-language Pathology services evaluation.
g) Skilled nursing: Initial assessment/re-assessment (Initial assessment of a new patient or sixty (60) Calendar Day re-assessment).
h) Skilled nursing: Treatment, teaching/training, observation/evaluation.
i) Skilled nursing: venipuncture.
j) Skilled nursing: Pre-filling insulin syringes/Medi-Planners.
k) Home Health Aide.

jj. Healthcare Access and Stabilization Program (HASP)

i. NCGS § 108A-148.1 requires the Department to submit an annual 42 C.F.R. § 438.6(c) Preprint for the Healthcare Access and Stabilization Program (HASP) for approval by CMS. Under HASP, eligible hospitals will receive payments from the PHP up to the average commercial rate (ACR) for all inpatient and outpatient hospital services, as specified in this Section and approved by CMS. All requirements in this Section are contingent on approval of the HASP preprint for the applicable time period by CMS and subject to change by the Department based on direction from CMS.

ii. All requirements in this Section apply to payments for services incurred during State Fiscal Year (SFY) 2023.

iii. The following hospital classes are eligible to receive HASP payments from the PHP:
   a) Class 1: All North Carolina acute care hospitals and critical access hospitals as defined in NCGS § 108A-145.3 included in the PHP's network that are not included in Class 2.
      1. An acute care hospital is defined by NCGS § 108A-145.3(1) as a hospital licensed in North Carolina that is not a freestanding psychiatric hospital, a freestanding rehabilitation hospital, a long-term care hospital, or a State-owned and State-operated hospital.
      2. A critical access hospital is as defined by 42 C.F.R. § 400.202.
   b) Class 2: North Carolina hospitals included in the PHP's network that are owned or controlled by the University of North Carolina Health Care System (UNCHS) and Vidant Medical Center (d/b/a ECU Health Medical Center).

iv. All inpatient and outpatient hospital services are eligible for HASP payments.

v. The PHP shall make interim and final HASP payments based on a uniform percentage increase. The Department will calculate a uniform percentage separately for each hospital class and separately for inpatient and outpatient hospital services based on the methodology described in the directed payment preprint approved by CMS.

vi. HASP payments will first be issued to the PHP on an interim basis for inpatient and outpatient services based on Medicaid Managed Care encounter data for a specified time period and measured as of a date specified by the Department and consistent with preprint approved by CMS.

a) The Department will calculate interim HASP payments for each hospital and PHP by multiplying the applicable uniform percentage increase, as described in *Section V.D.4.ii.v.*, by Medicaid Managed Care base payments from preliminary SFY 2023 encounter data for each hospital and PHP.
b) The Department will disburse to the PHP an amount equal to the total interim payments due to network hospitals (network status is based upon date of service) plus premium tax as calculated pursuant to NCGS § 105-228.5 and NCGS § 58-6-25(b).
c) The PHP shall distribute interim payments to eligible hospitals according to hospital-specific amounts calculated by the Department, as described in *Section V.D.4.ii.vi.a)*, within five (5) Business Days of receiving the payment from the Department. Penalties and interest apply to late payments as described in *Section V.D.4.l.viii.*, except that for the first HASP payment for services incurred during State Fiscal Year (SFY) 2023 to eligible hospitals, penalties as defined in *Section V.D.4.l.viii*., will not apply.

vii. No sooner than six (6) months following the end of the rate year, interim HASP payments will be reconciled by the Department based on actual managed care base payments made for services incurred during the SFY 2023 rate year.
a) The Department will calculate HASP reconciliation amounts as follows:
1. Determine final HASP payment amount for each hospital and PHP by multiplying the applicable uniform percentage increase, as described in *Section V.D.4.ii.v.*, by actual Medicaid Managed Care base payments from SFY 2023 encounter data.
2. Determine the reconciliation amounts for each hospital and PHP by subtracting the HASP interim payment amount, as calculated under *Section V.D.4.ii.vi.a)*, from the final HASP payment amount calculated in *Section V.D.4.ii.vii.a).1*.
b) The Department will calculate and disburse or recoup payments from the PHP based on the reconciliation amounts for network hospitals calculated under *Section V.D.4.ii.vii.a)*. The Department intends to operationalize disbursement or recoupments under this paragraph as an incremental or netting adjustment to a future HASP directed payment transaction and thereby mitigating the need for an additional standalone HASP transaction between the Department and the PHP or between the PHP and the hospital(s). In the event the Department is unable to operationalize the disbursement or recoupment as an incremental or netting transaction for one or more hospitals, the PHP shall do the following:
1. If additional disbursement is needed based on the reconciliation calculation by the Department, the PHP shall distribute HASP payment reconciliation amounts to eligible hospitals according to hospital-specific amounts calculated by the Department, as described in *Section V.D.4.ii.vii.a)*, within five (5) Business Days of receiving the payment from the Department. Penalties and interest apply to late payments as described in *Section V.D.4.l.viii*.

2. If recoupment is needed based on the reconciliation calculation by the Department, the PHP shall issue a notice of recoupment of the HASP payment reconciliation amounts to the eligible hospitals according to hospital-specific amounts calculated by the Department within the time frames defined in *Section V.H.1.f.*

viii. As necessary, the Department will reduce the amount of HASP directed payments to the lowest amount necessary to ensure that aggregate hospital assessments authorized under Article 7B of Chapter 108A of the North Carolina General Statutes do not exceed federal limits established under 42 C.F.R. § 433.68(f).

ix. The requirements specified in *Sections V.D.4.l.i.-ii., Section V.D.4.l.iv.,* and *Sections V.D.4.l.vi.-viii.* shall apply to HASP directed payments, except as provided in *Section V.D.4.ii.vi.c)*.

g. *Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, i. Quality Measures, iv.* is revised and restated in its entirety as follows:

iv. Beginning on January 1, 2024, the Department will implement a withhold program. The initial withhold performance period shall begin January 1, 2024, and shall run through December 31, 2024, with funds initially being withheld on July 1, 2024. The performance measures subject to withholds will align with the State's Quality Strategy. Additional details on the Department's withhold program are provided in *Section VI.C. Withholds* and in the North Carolina Medicaid Withhold Program Guidance.

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

1. The PHP shall, within eighteen (18) Calendar Days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim. The PHP shall have the capability to request additional information via x12 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The PHP shall implement the capability for EDI x12 277 and electronic method (portal or email) no later than January 1, 2024. If an extension is needed, the PHP may submit a request to the Department's Contract Administrator including the proposed implementation timeline and an explanation of how provider abrasion will be minimized during the extended implementation period.

h. *Section V.I. Financial Requirements, 6. Healthy Opportunities Pilot Payments, b. – d.* is revised and restated in its entirety as follows:

b. The PHP shall participate in a Pilot-specific value-based payment (VBP) program and be subject to value-based payment adjustments in accordance with the Department's assessment of the PHP's performance against specific targets detailed in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.

c. The PHP shall submit information required by the Department to receive value-based payments, including documentation demonstrating that the PHP has met the required targets, as described in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.
d. During the Healthy Opportunities Pilot Standard Plan Value-Based Payment Period One (1), the PHP will receive incentive payments from the Department based on completion of Pilot implementation milestones. Incentive payments will be tied to:
    i. Execution of contracts with all applicable Network Leads operating in the PHP's region as specified in *Section V.C.8. Opportunities for Health.*
    ii. Successful completion of the Department's Pilot Readiness Review as specified in *Section V.A.6. Readiness Requirements.*
    iii. Meeting the Department's Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment, as specified in *Section V.A.6. Readiness Requirements*.

i. *Section V.I. Financial Requirements, 6. Healthy Opportunities Pilot Payments* is revised to add the following:

e. During Healthy Opportunities Pilot Standard Plan Value-Based Payment Period Two (2), the PHP shall receive incentive payments from the Department for meeting service delivery performance, operational performance and financial management milestones as detailed in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.
f. During Healthy Opportunities Pilot Standard Plan Value-Based Payment Period Three (3), the PHP shall participate in the following types of Pilot value-based payment activities as detailed in the Department's Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual:
    i. The PHP shall earn incentive payments for meeting performance targets related to promoting Pilot enrollment, increasing referrals to Pilot services within underutilized Pilot domains, and supporting overall Pilot evaluation;
    ii. The PHP shall participate in Healthy Opportunities Pilot Program Withholds (HOP Withholds); and
    iii. The PHP shall annually submit quality measures to the Department for the Healthy Opportunities Pilot. Selected quality measures are included in the Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and include those that the PHP is already submitting as part of the broader managed care program. Selected measures align with Pilot eligibility criteria and may be impacted by the Pilot program. Quality measures collected in Healthy Opportunities Pilot Standard Plan Value-Based Payment Period Three (3) will be used as baseline data and will not be tied to VBP targets or payment in Healthy Opportunities Pilot Standard Plan Value-Based Payment Period Three (3). However, these quality measures may be tied to VBP targets and payments in future, at the discretion of the Department and CMS.

g. The Healthy Opportunities Pilot Standard Plan Value-Based Payment Periods are defined as follows:
    i. Standard Plan Pilot Value-Based Payment Period One (1): June 1, 2021 – June 30, 2022.
    ii. Standard Plan Pilot Value-Based Payment Period Two (2): July 1, 2022 – June 30, 2023.
    iii. Standard Plan Pilot Value-Based Payment Period Three (3): December 27, 2023 – October 31, 2024.

h. Pilot Administrative Payment Withhold
    i. The Department shall retain one percent (1%) of the PHP's Pilot administrative funds for each Pilot Service Delivery Period beginning in Pilot Service Delivery III in accordance with *Section III.D.32. PAYMENT AND REIMBURSEMENT*. Actions taken by the Department to withhold a portion of the PHP's Pilot administrative funds shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a).
    ii. Each applicable performance period subject to the Pilot Administrative Payment Withhold shall be defined by the Department in the Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.
    iii. Prior to implementing the Pilot Administrative Payment Withhold against the PHP pursuant to this Section and *Section III.D.32. PAYMENT AND REIMBURSEMENT*, the Department shall provide the PHP with written notice detailing the applicable withhold(s), the performance target(s) and applicable performance period, the amount being withheld, and the effective date in which the Department will begin withholding funds.
    iv. Performance Targets for Pilot Administrative Payment Withhold
        a) To receive the amounts retained under the Pilot Administrative Payment Withhold, the PHP, in partnership with its Tier 3 AMH and CIN Designated Pilot Care Management Entities, shall meet the performance target(s) during the applicable performance period as defined in the Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.
        b) For each identified target, the Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual shall define the Department's methodology for determining if the target has been met.
        c) Following the end of the applicable performance period, the Department shall issue a written Notice of HOP Withhold Determination to the PHP detailing the Department's determination of whether the PHP, in partnership with its Tier 3 AMH and CIN Delegated Pilot Care Management Entities, met the applicable target(s) during the performance period and the method and timeframes by which the PHP may dispute the Department's determination.
        d) If the Department determines that the PHP has met the performance target(s) by the end of the applicable performance period, the Department shall distribute the retained amount to the PHP no later than sixty (60) Calendar Days of the date on the written Notice of HOP Withhold Determination.

e) If the Department determines that the PHP has not met the target by the end of the applicable performance period, the Department will continue to keep the retained amounts, and the PHP will not be entitled to receive the payment.

v. Disputes of the Pilot Administrative Payment Withhold Determination
   a) If the PHP elects to dispute the Department's withhold determination, the PHP shall follow the process specified in *Section VI.A.e.vii. Dispute Resolution*.
   b) If the PHP elects to dispute the Department's withhold determination as provided in the Contract and the Department overturns its original decision, the Department shall pay the PHP any withheld amounts owed to the PHP by no later than sixty (60) Calendar Days of the date on the written notice of final decision. The PHP shall not be entitled to any interest or penalties from the Department for any disputed withheld amounts that were not paid by the Department during the pendency of the dispute resolution process.

II. Modifications to Section VI. Contract Performance of the Contract

Specific subsections are modified as stated herein.

a. *Section VI.C. Withholds* is revised and restated in its entirety as follows:

C. Withholds

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

2. The Department's withhold program, including any Bonus Pools that may be established, will conform to all of the following specified in 42 C.F.R. § 438.6(b)(3):
    i. Shall be for a fixed period of time and PHP performance is measured during the Rating Period under the Contract in which the Withhold Arrangement is applied;
    ii. Not be renewed automatically by the Department;
    iii. Made available to the PHP, regardless of whether the PHP is a public or private entity, under the same terms of performance;
    iv. Does not condition PHP participation in the withhold program on the PHP entering into or adhering to intergovernmental transfer agreements; and
    v. Are necessary to support Medicaid Managed Care program priorities and initiatives as specified in the Department's Quality Strategy.
3. Reserved.
4. Prior to implementing a withhold pursuant to this Section and *Section III.D.32.i. Other Managed Care Payment Terms and Conditions,* the Department shall provide the PHP with written notice detailing the applicable performance measures subject to withhold(s) and the performance period for achieving the associated performance target(s), the percentage being withheld, and the effective date in which the Department will begin withholding funds.
    i. For the initial year of the withhold program, the notice required under this Section shall be provided to the PHP at least fourteen (14) Calendar Days prior to the start of the withhold performance period.
    ii. For any subsequent years of the withhold program, the notice shall be provided to the PHP at least thirty (30) Calendar Days prior to the start of the withhold performance period.
5. Notice of Withhold Determination
    i. Following the end of the applicable withhold performance period, the Department shall issue a written Notice of Withhold Determination to the PHP detailing the following:
        a) The Department's determination of whether the PHP fully met, partially met, or did not meet the applicable withhold performance targets during the performance period; and
        b) The method and timeframes by which the Contractor may dispute the Department's determination.
6. Payment of any withheld amounts owed to the PHP shall be made by the Department to the PHP by no later than sixty (60) Calendar Days of the date on the written Notice of Withhold Determination.
7. Disputes of the Withhold Determination
    i. If the PHP elects to dispute the Department's withhold determination, the PHP shall follow the process specified in *Section VI. A. e. vii. Dispute Resolution.*
    ii. If the Contractor elects to dispute the Department's withhold determination as provided in the Contract and the Department overturns its original decision, the Department shall pay the PHP any withheld amounts owed to the PHP by no later than sixty (60) Calendar Days of the date on the written notice of final decision. The PHP shall not be entitled to any interest or penalties from the Department for any

disputed withheld amounts that were not paid by the Department during the pendency of the dispute resolution process.

8. Bonus Pools for the Withhold Program
    i. In its sole discretion and based on the availability of funds, the Department may implement a Bonus Pool for specific performance measures as an incentive for the PHP to further improve its performance on the identified measure(s) during the applicable performance period.
    ii. Any established Bonus Pool(s) shall include a Loss Limit that is set by the Department and defined in the North Carolina Medicaid Withhold Program Guidance.
    iii. The North Carolina Medicaid Withhold Program Guidance shall define the criteria for participation in a Bonus Pool and how any PHP eligible to participate may be awarded Bonus Pool funds.
    iv. If no PHP is eligible to participate in an established Bonus Pool, the funds will be retained by the Department.
    v. Following the issuance of the Notice of Withhold Determination and the resolution of any disputes that may arise under *Section VI.A.e.vii. Dispute Resolution* regarding the withhold determination, the Department shall provide written notice to the PHP detailing the establishment of any Bonus Pool(s) based on the availability of funds, whether the PHP was eligible to participate in any established Bonus Pool(s), and whether the PHP was awarded funds from any of the Bonus Pool(s). As applicable, payment of any Bonus Pool funds owed to the PHP shall be made by the Department to the PHP by no later than sixty (60) Calendar Days of the date on the written notice.
    vi. The Department's determination to award funds to a PHP that the Department deems eligible to participate in a Bonus Pool shall be made in the Department's sole discretion based on the criteria specified in the North Carolina Medicaid Withhold Program Guidance and is not subject to dispute by the PHP.
9. Under no circumstances shall a PHP receive payments from the Department under the withhold program, including any funds that may be received through a Bonus Pool, in excess of five percent (5%) of the PHP's total capitation payments received during the Rating Period that is associated with the Withhold Arrangement. 42 C.F.R. § 438.6(b)(2).
10. Prior to implementing material changes to existing and/or adding new performance measures to the withhold program, the Department shall provide the PHP an opportunity to review and provide feedback to the Department on the proposed changes and additions to the program.

III. Modifications to Section VII. Attachments

Specific subsections are modified as stated herein.

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

2. ***Attachment M. Policies* is revised to add** *Attachment M. Policies, 15. 340B Ceiling Rate File Confidentiality Notice* and attached to this Amendment.

IV. Effective Date

This Amendment is effective November 1, 2023, unless otherwise explicitly stated herein, subject to approval by CMS.

V. Other Requirements

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

Execution:

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

Department of Health and Human Services

_____ Date: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

PHP Name

_____ Date: _____

PHP Authorized Signature

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

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

1. **Contracts between the PHP and Providers, must, at a minimum, include provisions addressing the following:**
    a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PHP utilizes the definition as found in Section III.A. of the PHP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
    e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the PHP's insolvency the contract must address:
            1. Transition of administrative duties and records; and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's network participation requirements as outlined in the PHP's Credentialing and Re-credentialing Policy and to notify the PHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
        ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:

1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
2. During Provider Credentialing under Full Implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

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

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

i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance that the PHP may not cover or continue to cover specific services and the Member to receive the service; and

ii. Any provider's responsibility to collect applicable Member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

i. Provider Accessibility. The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PHP's standards for provider accessibility.

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

k. Medical Records. The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:

i. Maintain confidentiality of Member medical records and personal information and other health records as required by law;

ii. Maintain adequate medical and other health records according to industry and PHP standards; and

iii. Make copies of such records available to the PHP and the Department in conjunction with its regulation of the PHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

l. Member Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the Member in regard to Member appeals and grievance procedures.

m. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic

increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5).

n. Data to the Provider: The contract must address the PHP's obligations to provide data and information to the provider, such as:
    i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
    ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
    iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.

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

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

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

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

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

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

u. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's

Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.

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

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

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

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

z. Clinical Records Requests for Claims Processing: the contract shall indicate that the PHP shall accept delivery of any requested clinical documentation through a mutually agreed

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

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

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

cc. Designated Pilot Care Management Entities: For all contracts with Designated Pilot Care Management Entities, provisions that indicate:

i. The Designated Pilot Care Management Entity shall:

a) Utilize NCCARE360 for functions outlined in *PHP Contract Sections V.C.8.e.ii.a. and V.C.8.g.xiv.*

b) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, v.b.*

c) Manage transitions of care for Pilot-enrolled Members as outlined in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, a.v.c. Transitional Care Management* for Members that change health plans.

d) Perform Pilot-related care management responsibilities as outlined in *PHP Contract Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot*.

e) Abide by the Pilot provider complaint process described in *PHP Contract Section V.D.5 Provider Grievances and Appeals Appeals, j. HSO Grievances related to the Healthy Opportunities Pilot*.

f) Adhere to the technology requirements described in *PHP Contract Section V.K. Technical Specifications, 8. Healthy Opportunities Pilot Technology Specifications.*

g) If the Designated Pilot Care Management Entity is a Tier 3 AMH or CIN, it must participate in the Healthy Opportunities Pilot Care Management

Payment Withhold outlined in this Contract and described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments***.** Designated Pilot Care Management Entities that are Local Health Departments are excluded from participation in the Healthy Opportunities Pilot Care Management Payment Withhold.

ii. The PHP shall:
   a) Make Pilot care management payments including, as applicable, any amounts withheld as part of the Pilot Care Management Payment Withhold, to Designated Pilot Care Management Entities for Pilot-enrolled members as outlined in *Section III.D.32.e.iii. Pilot Care Management Payments*.
   b) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, PHP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.

iii. The PHP shall include Department-developed standard contract language included in the Advanced Medical Home (AMH) Manual in its contracts with Designated Pilot Care Management Entities.

iv. Healthy Opportunities Pilot Care Management Payment Withhold (Pilot Care Management Payment Withhold)
   a) The Pilot Care Management Payment Withhold is defined as a set percentage of the monthly care management payment for which the Tier 3 AMH or CIN Delegated Pilot Care Management Entity, in partnership with the PHP and its PHP(s)' other Tier 3 AMH or CIN Delegated Pilot Care Management Entities, is required to meet specific performance target(s) described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* as a condition to receive the retained portion of the payment from the PHP.
   b) The amount of the Pilot Care Management Payment Withhold shall be set at one percent (1%) of the monthly fixed Pilot care management payments made to the Tier 3 AMH or CIN Designated Pilot Care Management Entity by the PHP.
   c) Within fifteen (15) Calendar Days of the PHP's receipt of the written notice of withhold from the Department described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* in advance of each performance period subject to a Pilot Care Management Payment Withhold, the PHP shall provide written notification to the Tier 3 AMH or CIN Designated Care Management Entity of the applicable performance period, details of the associated performance target(s) that is required to earn the retained funds, and the effective date that funds will start being withheld.

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

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

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

g) If a determination is made in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* that the performance target(s) have not been met by the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, by the end of the applicable performance period, the Tier 3 AMH or CIN Delegated Pilot Care Management Entity is not entitled to the retained funds.

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

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

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

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

e. Advanced Medical Home Manual

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

a. Compliance with State and Federal Laws

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

b. Hold Member Harmless

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

c. Liability

The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].

d. Non-discrimination Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

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

f. Access to provider records

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

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

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

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

g. G.S. 58-3-225, Prompt claim payments under health benefit plans.

Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, PHP shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The [Provider] shall submit all claims for a date of service on or before June 30, 2023, to the [Company] for processing and payments within one-hundred-eighty (180) Calendar Days) from the date of covered service or discharge (whichever is later), except for pharmacy point of sale claims which shall be submitted within three-hundred sixty-five (365) Calendar Days of the date of the provision of care. The [Provider] shall submit all claims with a date of service on or after July 1, 2023, to the [Company] for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim

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

i. *For Medical claims (including behavioral health):*

   1. *The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to process the claim. The PHP shall have the capability to request additional information via 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The PHP shall implement the capability for EDI 277 and electronic method (portal or email) January 1, 2024, or later date if approved by the Department .*
   2. *The [Company] shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.*
   3. *A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.*

ii. *For Pharmacy Claims:*

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

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

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

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

v. *Failure to pay a clean claim within thirty (30) Calendar Days of receipt will result in the [Company] paying the [Provider] a penalty equal to one percent (1%) of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.*

vi. *The [Company] shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require the [Provider] to requests the interest or the penalty.*

h. Contract Effective Date.

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

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

i. Tobacco-Free Policy.

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

ii. Providers Subject to a Partial Tobacco-Free Policy
Starting April 1, 2024, contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings, the following policies shall be required:

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

1. *Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee.*

2. *Outdoor areas of the property, under [PROVIDER'S] control as owner or lessee shall:*
   a) *Ensure access to common outdoor space(s) free from exposure to tobacco use.*
   b) *Prohibit staff/employees from using tobacco products anywhere on the property.*

Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes;

family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

iii. Providers subject to Full Tobacco-Free Policy

Starting April 1, 2024, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

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

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Attachment M. Policies, 15. 340B Ceiling Rate File Confidentiality Notice

340B Ceiling Rate File Confidentiality Notice

Contractor is required to include the following Confidentiality Notice on each redisclosure of the 340B Ceiling Rate File received from the Department to its Pharmacy Benefits Manager (PBM) in accordance with *Section V.C.3. Pharmacy Benefits* of the Contract:

IMPORTANT CONFIDENTIALITY NOTICE

This 340B Ceiling Rate File ("File"), which has been disclosed to you is protected by federal confidentiality laws (Section 1927(b)(3)(D) of the Social Security Act) and is also considered confidential information under [Health Plan's] Prepaid Health Plan Contract ("Contract") with the North Carolina Department of Health and Human Services, Division of Health Benefits ("Department"). This file is being shared with you as a subcontractor of [Health Plan] pursuant to [Health Plan's] Contract with the Department for the sole purpose of assisting [Health Plan] with processing 340B drug claims in accordance with the terms and conditions of its Contract with the Department. Subcontractor is required to maintain the confidentiality of this File and shall not further disclose, share, modify content, release, or use the File for any purpose outside of assisting [Health Plan] with the processing of 340B drug claims.