Amendment Number 18 (19)
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 updates related to the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

I. *Section V. Scope of Services*;
II. *Section VII. Attachments*; and
III. *Section X. Seventh Revised and Restated Summary of Contractual Payment and Risk Sharing Terms*.

The Parties agree as follows:

I. <u>Modifications to Section V. Scope of Services of the Contract</u>

Specific subsections are modified as stated herein.

a. *Section V.D. Providers 2. Provider Network Management, C. Provider Contracting. xxiv. Tobacco-free Policy, a*. is revised and restated as follows:

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

b. *Section V.D. Providers 2. Provider Network Management, C. Provider Contracting. xxiv. Tobacco-free Policy, b.* is revised and restated as follows:

b. Beginning on the date that BH I/DD Tailored Plans launch, the following partial tobacco-free policy shall be required in Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities:

c. ***Section V.D. Providers 2. Provider Network Management, C. Provider Contracting. xxiv. Tobacco-free Policy, c. Provider Monitoring, 1.*** **is revised and restated as follows:**

1. Beginning on the date that BH I/DD Tailored Plans launch, the PHP shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The PHP shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The PHP shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

d. ***Section V.D. Providers 4. Provider Payments, f. Hospital Payments for Behavioral Health Claims, i.*** **is revised and restated as follows:**

i. For dates of service on or after January 1, 2024, the PHP shall reimburse providers for Inpatient Behavioral Health services no less than one hundred percent (100%) of the Federal Fiscal Year 2024 Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) Base Per Diem rate as published in Addendum A CMS-1783-F by CMS ($895.63), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement established on or after January 1, 2024. For any claims that the PHP is required to reprocess to comply with this Section, the PHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.H.1.d.iv*).

e. ***Section V. D. Providers 4. Provider Payments*** **is revised to add the following:**

kk. Payment for Outpatient Behavioral Health Services

i. For dates of service on or after January 1, 2024, the PHP shall reimburse providers for the following Outpatient Behavioral Health services no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement established on or after January 1, 2024:

a) Psychiatric Diagnostic Evaluation:
b) Development/Psychological Testing and Evaluation:
c) Therapeutic, Prophylactic, or Diagnostic Injection:
d) Office Visit Evaluation and Monitoring Codes for Psychiatrists and Psychiatric Nurse Practitioners:
e) Psychotherapy:
f) Psychotherapy for Crisis:
g) Family/Group Therapy:
h) Electroconvulsive Therapy:
i) Tobacco Cessation; and
j) Screening, Brief Intervention, and Referral to Treatment.

ii. For any claims that the PHP is required to reprocess to comply with this Section, the PHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.H.1.d.iv).*

ll. Payment for Enhanced Mental Health Services

i. For dates of service on or after January 1, 2024, the PHP shall reimburse providers for the following Enhanced Mental Health services no less than the Department's Medicaid Fee for

Service Fee Schedule rate unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement established on or after January 1, 2024:

a) Partial Hospitalization; and
b) Peer Support.

ii. For dates of service on or after January 1, 2024, the PHP shall reimburse providers for the following Enhanced Mental Health services, if covered under EPSDT, no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement established on or after January 1, 2024:

a) Community Support Team;
b) Assertive Community Treatment;
c) Multi-Systemic Therapy;
d) Intensive In-Home Services;
e) Child and Adolescent Day Treatment;
f) Psychosocial Rehabilitation; and
g) Behavioral Health Long-Term or High Risk Intervention Residential.

iii. For any claims that the PHP is required to reprocess to comply with this Section, the PHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.H.1.d.iv)*.

mm. Payment for Research Based Intensive Behavioral Health Treatment Services

i. For dates of service on or after January 1, 2024, the PHP shall reimburse providers for Research Intensive Behavioral Health Treatment Services no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement established on or after January 1, 2024. For any claims that the PHP is required to reprocess to comply with this Section, the PHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.H.1.d.iv)*.

II. Modifications to Section VII. Attachments

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

III. Section X. Seventh Revised and Restated Summary of Contractual Payment and Risk Sharing Terms is revised and restated in its entirety as *Section X. Eighth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms.*

IV. Effective Date

This Amendment is effective January 1, 2024, 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. Eighth 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, 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

Beginning on the date that BH I/DD Tailored Plans launch, 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

Beginning on the date that BH I/DD Tailored Plans launch, 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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SECTION X. EIGHTH REVISED AND RESTATED SUMMARY OF CONTRACTUAL PAYMENT AND RISK SHARING TERMS

Part 1: July 1, 2023 – November 30, 2023

This *Section X. Part 1: July 1, 2023 – November 30, 2023,* summarizes capitation payment and risk sharing terms and figures included elsewhere in the Standard Plan Rate Book for State Fiscal Year 2024 dated December 19, 2023, for the period spanning July 1, 2023 – November 30, 2023. The ABD, TANF and Other Related Children ages 1-20, and TANF and other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,936.67	$1,911.69	$1,981.75	$1,837.41	$1,705.87	$1,645.45
TANF, Newborns (<1)	$1,090.47	$1,045.57	$1,025.53	$948.74	$914.76	$894.59
TANF, Children (1–20)	$190.84	$171.92	$169.21	$170.19	$166.81	$165.69
TANF, Adults (21+)	$442.25	$458.44	$444.78	$441.79	$444.24	$424.95
Maternity Event	$13,827.01	$14,525.68	$14,663.38	$14,133.67	$13,398.23	$14,326.83

Non-Expansion Target Service Ratio Underlying Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.2%	91.9%	91.7%	91.4%	91.7%	91.5%
TANF, Newborns (<1)	91.9%	91.7%	91.5%	91.0%	91.4%	91.3%
TANF, Children (1–20)	89.4%	89.4%	88.7%	87.3%	88.5%	88.9%
TANF, Adults (21+)	91.2%	91.1%	90.7%	90.5%	90.7%	90.7%
Maternity Event	94.7%	94.5%	94.4%	94.2%	94.4%	94.3%

Non-Expansion Minimum PCP Expenditures as a Percentage of Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.6%	5.1%	4.8%	5.1%	5.6%	4.9%
TANF, Newborns (<1)	11.1%	12.7%	12.7%	12.6%	13.8%	12.5%
TANF, Children (1–20)	18.9%	18.9%	18.4%	17.1%	19.6%	17.6%
TANF, Adults (21+)	9.9%	10.3%	10.1%	9.7%	10.7%	9.0%
Maternity Event	22.4%	21.9%	21.4%	18.4%	19.2%	20.0%

Non-Expansion Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1–20)	TANF, Adult (21+)	Maternity Event	Total Non-Expansion
89.1%	88.8%	85.8%	88.1%	92.0%	88.0%

Part 2. December 1, 2023 – December 31, 2023

This *Section X. Part 2: December 1, 2023 – December 31, 2023,* summarizes capitation payment and risk sharing terms and figures included elsewhere in the Standard Plan Rate Book for State Fiscal Year 2024 dated December 19, 2023, for the period spanning December 1, 2023 – December 31, 2023. The ABD, TANF and Other Related Children ages 1-20, and TANF and other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,939.04	$1,909.03	$1,982.36	$1,838.04	$1,706.60	$1,643.37
TANF, Newborns (<1)	$1,091.44	$1,044.12	$1,025.43	$948.64	$914.74	$893.48
TANF, Children (1–20)	$190.32	$171.71	$168.47	$169.45	$166.07	$165.51
TANF, Adults (21+)	$442.14	$457.83	$444.24	$441.28	$443.76	$424.44
Maternity Event	$13,825.75	$14,514.83	$14,659.18	$14,129.50	$13,394.77	$14,316.04
Newly Eligible, Ages 19 Years–24 Years	$227.63	$233.87	$229.02	$228.18	$228.76	$219.06
Newly Eligible, Ages 25 Years–34 Years	$346.33	$356.12	$348.62	$347.26	$348.08	$333.27
Newly Eligible, Ages 35 Years–44 Years	$534.05	$549.46	$537.77	$535.60	$536.77	$513.91
Newly Eligible, Ages 45 Years–64 Years	$865.45	$890.76	$871.67	$868.06	$869.88	$832.78

Non-Expansion Population Target Service Ratio Underlying Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.1%	92.0%	91.7%	91.4%	91.7%	91.6%
TANF, Newborns (<1)	91.9%	91.8%	91.5%	91.0%	91.4%	91.4%
TANF, Children (1–20)	89.6%	89.5%	89.1%	87.7%	88.9%	89.0%
TANF, Adults (21+)	91.2%	91.2%	90.8%	90.6%	90.8%	90.8%
Maternity Event	94.7%	94.6%	94.4%	94.3%	94.5%	94.4%

Expansion Population Target Service Ratio Underlying Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Newly Eligible, Ages 19 Years–24 Years	90.1%	90.2%	89.8%	89.6%	89.7%	89.7%
Newly Eligible, Ages 25 Years–34 Years	90.9%	90.9%	90.6%	90.3%	90.5%	90.5%
Newly Eligible, Ages 35 Years–44 Years	91.4%	91.4%	91.0%	90.8%	91.0%	91.0%
Newly Eligible, Ages 45 Years–64 Years	91.7%	91.7%	91.4%	91.1%	91.4%	91.3%
Maternity Event	94.7%	94.6%	94.4%	94.3%	94.5%	94.4%

Non-Expansion Minimum PCP Expenditures as a Percentage of Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.6%	5.1%	4.8%	5.1%	5.6%	4.9%
TANF, Newborns (<1)	11.1%	12.7%	12.7%	12.6%	13.8%	12.5%
TANF, Children (1–20)	18.9%	18.9%	18.5%	17.2%	19.6%	17.7%
TANF, Adults (21+)	10.0%	10.3%	10.1%	9.8%	10.7%	9.0%
Maternity Event	22.4%	21.9%	21.4%	18.4%	19.2%	20.0%

Non-Expansion Population Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1–20)	TANF, Adult (21+)	Maternity Event	Total Non-Expansion
88.9%	88.6%	86.0%	88.0%	91.8%	88.0%

Expansion Population Contractual Minimum MLR Thresholds by Rating Group

Newly Eligible, Ages 19 Years–24 Years	Newly Eligible, Ages 25 Years–34 Years	Newly Eligible, Ages 35 Years–44 Years	Newly Eligible, Ages 45 Years–64 Years	Maternity Event	Total Expansion
86.7%	87.5%	88.0%	88.4%	91.8%	88.0%

Part 3. January 1, 2024 – June 30,2024

This *Section X. Part 3: January 1, 2024 – June 30, 2024,* summarizes capitation payment and risk sharing terms and figures included elsewhere in the Standard Plan Rate Book for State Fiscal Year 2024 dated December 19, 2023, for the period spanning January 1, 2024 – June 30, 2024. The ABD, TANF and Other Related Children ages 1-20, and TANF and other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Capitation Rates by Region and COA

Category of Aid	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,937.74	$1,908.58	$1,981.80	$1,837.84	$1,706.31	$1,643.24
TANF, Newborns (<1)	$1,090.89	$1,044.11	$1,025.19	$948.87	$915.04	$893.49
TANF, Children (1–20)	$191.73	$173.07	$169.95	$171.25	$167.38	$166.79
TANF, Adults (21+)	$440.28	$455.56	$442.18	$440.75	$441.92	$421.94
Maternity Event	$13,811.77	$14,499.99	$14,644.02	$14,113.90	$13,381.34	$14,301.87
Newly Eligible, Ages 19 Years–24 Years	$229.01	$235.11	$230.25	$230.21	$230.14	$219.95
Newly Eligible, Ages 25 Years–34 Years	$348.45	$358.03	$350.52	$350.39	$350.19	$334.65
Newly Eligible, Ages 35 Years–44 Years	$537.34	$552.41	$540.71	$540.45	$540.05	$516.04
Newly Eligible, Ages 45 Years–64 Years	$870.81	$895.57	$876.46	$875.96	$875.21	$836.26

Non-Expansion Population Target Service Ratio Underlying Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.1%	92.0%	91.7%	91.4%	91.7%	91.7%
TANF, Newborns (<1)	91.9%	91.8%	91.5%	91.0%	91.4%	91.4%
TANF, Children (1–20)	89.7%	89.5%	89.1%	87.7%	89.0%	89.0%
TANF, Adults (21+)	91.2%	91.2%	90.9%	90.6%	90.8%	90.8%
Maternity Event	94.7%	94.6%	94.4%	94.3%	94.5%	94.4%

Expansion Population Target Service Ratio Underlying Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Newly Eligible, Ages 19 Years–24 Years	90.1%	90.3%	89.9%	89.6%	89.8%	89.7%
Newly Eligible, Ages 25 Years–34 Years	90.9%	90.9%	90.6%	90.3%	90.5%	90.5%
Newly Eligible, Ages 35 Years–44 Years	91.4%	91.4%	91.1%	90.8%	91.0%	91.0%
Newly Eligible, Ages 45 Years–64 Years	91.8%	91.7%	91.4%	91.2%	91.4%	91.4%
Maternity Event	94.7%	94.6%	94.4%	94.3%	94.5%	94.4%

Non-Expansion Minimum PCP Expenditures as a Percentage of Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.6%	5.1%	4.8%	5.1%	5.6%	4.9%
TANF, Newborns (<1)	11.2%	12.7%	12.7%	12.6%	13.8%	12.6%
TANF, Children (1–20)	18.8%	18.7%	18.4%	17.0%	19.5%	17.5%
TANF, Adults (21+)	9.9%	10.3%	10.1%	9.7%	10.6%	8.9%
Maternity Event	22.4%	21.9%	21.4%	18.4%	19.2%	20.0%

Non-Expansion Population Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1–20)	TANF, Adult (21+)	Maternity Event	Total Non Expansion
88.9%	88.6%	86.1%	88.0%	91.8%	88.0%

Expansion Population Contractual Minimum MLR Thresholds by Rating Group

Newly Eligible, Ages 19 Years–24 Years	Newly Eligible, Ages 25 Years–34 Years	Newly Eligible, Ages 35 Years–44 Years	Newly Eligible, Ages 45 Years–64 Years	Maternity Event	Total Expansion
86.8%	87.5%	88.0%	88.4%	91.8%	88.0%