

Amendment Number 9 (10)
Prepaid Health Plan Services
#30-190029-DHB – PHP

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 Healthy Opportunities Pilot in the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

1. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
2. Section V. Scope of Services;
3. Section VI.A. Contract Violations and Noncompliance; and
4. Section VII. Attachments A – N.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

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

Pilot Eligibility and Service Assessment (PESA): A Department-standardized tool in NCCARE360 that facilitates the documentation of a Member’s eligibility for the Healthy Opportunities Pilot and Pilot services, and the authorization of Pilot services.

- b. Section III.B. Acronyms is revised to add the following new acronym.**

PESA: Pilot Eligibility and Service Assessment

2. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

- a. Section V.B. Members, 3. Member Engagement, e. Member Services Department, iii. is revised and restated as follows:**

iii. The Member Services staff shall be responsible, at a minimum, for the following functions:

- a) Explaining operation of the PHP, including the role of the PCP and what to do in an emergency or urgent medical situation;
- b) Assisting with arranging non-emergency transportation for Members;
- c) Assisting Members in selecting or changing AMH/PCP;
- d) Educating and assisting Members with obtaining services under Medicaid Managed Care, including out-of-network services;
- e) Explaining transition of care requirements and care management services offered by the PHP;
- f) Fielding and responding to Members’ questions and complaints;
- g) Clarifying information in the Member Handbook;

- h) Advising Members of and assisting Members with the appeals, grievance, and State Fair Hearing processes;
 - i) Referring Members to the Department's Enrollment Broker if an individual requests information regarding how to enroll in or select a new PHP;
 - j) Referring Members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues; and
 - k) Educating and assisting Members with obtaining Healthy Opportunities Pilot services including how to access services and instructions for submitting a Pilot-related grievance.
- b. Section V.B. Members, 3. Member Engagement, f. Member Services Website, iii. is revised to add the following:**
- i) Information on Healthy Opportunities Pilot services available, including how to access services and instructions for submitting a Pilot-related grievance.
- c. Section V.B. Members, 3. Member Engagement, m. Member Handbook, iv. is revised to add the following:**
- x) Information on Healthy Opportunities Pilot services, including how to access services and instructions for submitting a Pilot-related grievance.
- d. Section V.B. Members, 6. Member Grievances and Appeals, c. Member Grievance Process is revised to add the following:**
- ix. Healthy Opportunities Pilot Services Grievances
 - a) The PHP shall allow a Member or authorized representative to file a grievance related to Healthy Opportunities Pilot Services.
 - b) Healthy Opportunities Pilot Service Member grievances may include:
 - 1. Grievances regarding eligibility determination for Pilot program or Pilot service(s);
 - 2. Grievances regarding Pilot service authorization; and
 - 3. Other grievances regarding access to, or coverage of, Pilot services.
 - c) The PHP shall address, track, and report to the Department all Healthy Opportunities Pilot Service Member grievances consistent with the requirements of this Section.
 - d) The PHP shall develop a Healthy Opportunities Pilot Member Grievance Policy that outlines the PHP's approach to meet the requirements of this Section. The PHP shall submit the Policy for review and approval by the Department upon request.
 - e) The PHP shall accept, track, and address Members' Healthy Opportunity Pilot Service grievances routed from the Department, Ombudsman, or a Network Lead.
 - f) If the PHP receives a Member grievance unrelated to PHP Healthy Opportunity Pilot Service responsibilities, the PHP shall route Healthy Opportunity Pilot Service Member grievances to the appropriate entity (e.g., Network Lead for HSO network issues, Designated Pilot Care Management Entity for care management issues), as applicable, within three (3) Business Days of receipt. The PHP shall manage grievances for passthrough service authorizations regardless of whether the Member was enrolled with the PHP at the passthrough service determination and should not route to a Member's prior PHP for resolution.
 - g) The PHP shall provide information on its Healthy Opportunity Pilot Service Member grievances process to a Network Lead at the Network Lead's request.

e. Section V.C. Benefits and Management, 4. Transition of Care, c. viii. is revised and restated as follows:

viii. The PHP shall establish a written PHP Transition of Care Policy.

- a) The PHP Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and processes and procedures for:
 1. Coordination of care for Members who have an ongoing special condition;
 2. Coordination of Members transitioning from Medicaid Fee-for-Service into Medicaid Managed Care;
 3. Coordination of Members transitioning from Local Management Entity/Managed Care Organization (LME/MCOs) into Standard Plans;
 4. Coordination of Members transitioning from Medicaid Managed Care into Medicaid Fee-for-Service;
 5. Coordination of Members transitioning from the PHP to another PHP, including the Tribal Option or other types of PHPs established by the Department;
 6. Coordination for Members in the Management of Inborn Errors of Metabolism (IEM) Program, as defined in *Section V.C.7. Prevention and Population Health Management Programs*;
 7. Coordination of services delivered under other sources of coverage, including Medicaid Fee-for-Service;
 8. Notification of the Department of members who have had two (2) or more visits to the emergency department for a psychiatric problem or two (2) or more episodes using behavioral health crisis services within the prior eighteen (18) months as defined in Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48;
 9. Coordination of Members enrolled in the Healthy Opportunities Pilot transitioning to another PHP (including transitions to BH I/DD Tailored Plans and other types of PHPs established by the Department as they become operational), the Tribal Option or to NC Medicaid Direct; and
 10. Other requirements as defined in this Section.
- b) The PHP shall submit the PHP Transition of Care Policy to the Department for review and approval ninety (90) Calendar Days after the Contract Award. The PHP shall submit an updated version of its Transition of Care Policy to reflect transitions of Pilot enrollees to the Department for review and approval upon request by the Department.

f. Section V.C. Benefits and Management, 4. Transition of Care, is revised to add to following:

- e. Transition of Care for Members enrolled in the Healthy Opportunities Pilot
 - i. The PHP shall develop policies, processes, and procedures to support Pilot enrollees transitioning between PHPs, the Tribal Option and NC Medicaid Direct.
 - ii. Pilot enrollees moving to another PHP or delivery system:
 - a) Upon notification via the Department's standard eligibility file that a Pilot enrollee is transitioning to another PHP or the Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, the PHP or its Designated Pilot Care Management Entity shall provide Pilot-related information to the PHP or Tribal Option using a Transition of Care Assessment in NCCARE360 and through DHB's defined processes in the Healthy Opportunities Pilot Transition of Care Protocol, including:
 1. Pilot enrollment status;
 2. Member consent documentation; and
 3. Completed Pilot Eligibility and Service Assessment (PESA), including:
 - i. Pilot-qualifying physical/behavioral health and social risk factor(s);

- ii. Current and previously authorized Pilot services and duration of services (e.g., healthy food box for three (3) months);
 - iii. Documentation of Member's Pilot consents;
 - iv. Date of Pilot enrollment; and,
 - v. Payments made for Pilot services.
- b) The PHP shall end date its coverage of the Pilot enrollee and add the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, in NCCARE360. The end date shall be the later of the date of disenrollment from the PHP or the date of notification of retroactive disenrollment provided to the PHP by the Department via the Department's standard eligibility file.
- c) If the transition results in a change to the Member's care management team, the PHP shall inform the care management team of the change and ensure that medical records, including the Pilot information in the Member's Care Plan when available, is transferred to the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.
- d) The PHP shall notify the Network Lead and HSO(s) of the change in PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, and where invoices for Pilot services for that Pilot enrollee should be routed.
- e) The PHP shall bear the financial responsibility of authorized Pilot services that have been delivered to the Member while still enrolled with its PHP even if the associated invoice is received after the Member is no longer enrolled with the PHP.
- f) The PHP shall bear the financial responsibility of a passthrough service and/or an authorized, one-time Pilot service (e.g., home modifications) which has been authorized and started while the Member is still enrolled with the PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members. Such services shall be considered non-transferrable to a receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.
- g) If the PHP receives an invoice that is not within its payment responsibilities, as defined by the Department, the PHP shall deny the invoice, following existing Pilot invoice denial steps defined in the Healthy Opportunities Pilot Payment Protocol and the Healthy Opportunities Pilot NCCARE360 Invoice File(s) Companion Guides, and notify the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, and Network Lead.
- h) Pilot enrollees transitioning to Medicaid Direct or Tribal Option, in advance of launch of the Healthy Opportunities Pilot for Tribal Option Members:
 - 1. The PHP shall end date its coverage of the Pilot enrollee in NCCARE360 to be the later of the date of disenrollment or notification of retroactive disenrollment provided by the Department via the Department's standard eligibility file.
 - 2. Within ten (10) Calendar Days of notification via the Department's standard eligibility file that a Pilot enrollee is transitioning to Medicaid Direct or Tribal Option, in advance of the launch of Healthy Opportunities Pilot for Tribal Option Members, the PHP shall inform the HSO(s) outside of NCCARE360 (e.g., by phone or through the HSO's Network Lead) of the date of disenrollment. The PHP shall bear the financial responsibility of authorized Pilot services that have been delivered to the Pilot enrollee through the date of disenrollment or the date that the HSO was notified, whichever is later. The PHP will not be required to return pilot funding to the Department for authorized Pilot services delivered prior to the date of disenrollment.

3. If there are authorized services remaining on a referral on the date of disenrollment, the PHP shall work with the HSO(s) to close the case for those services and inform the HSO that those services are no longer reimbursable by Medicaid.
- iii. Pilot enrollees enrolling in the PHP
 - a) The PHP shall ensure that Pilot enrollees who were receiving Pilot services authorized by the former PHP or Tribal Option, upon launch of the Healthy Opportunity Pilot for Tribal Option Members:
 1. Continue receiving the services authorized by the former PHP or Tribal Option for up to ninety (90) Calendar Days from the time of enrollment with the PHP or until the authorized number or duration of current Pilot service expires, whichever comes first; and,
 2. Are reassessed for ongoing Pilot eligibility and service mix within ninety (90) Calendar Days of transfer to the PHP.
 - b) The PHP shall accept the Transition of Care Assessment in NCCARE360 from the former PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.
 - c) If the Member remains Pilot-enrolled and the transition results in a change to the Member's care management team, the PHP shall ensure that the Member has been assigned a new care management team that meets their needs and preferences and that is able to assume Pilot-related responsibilities. The PHP shall provide the new care management team with Pilot-related information from the Member's Care Plan.
 1. If the Pilot enrollee will receive care management from a new Designated Pilot Care Management Entity, the PHP shall send the Transition of Care Assessment in NCCARE360 to the new Designated Pilot Care Management Entity.
 - iv. Healthy Opportunities Pilot Continuation of Care
 - a) In an instance where an HSO that is providing Pilot services to a PHP's Members is terminated from the Network Lead's network, the PHP shall:
 1. Ensure that the care management team at the Designated Pilot Care Management Entity identifies an alternative HSO in the Pilot network providing that service, if possible.
 2. Work with the care management team to authorize the continuation of that services at the alternative HSO.

g. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilot to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xii. is revised and restated as follows:

- xii. Member Outreach and Identification of Potentially Pilot-Eligible Members
 - a) The PHP shall conduct outreach to educate Members about the Pilots, Pilot services, and how to self-refer for an assessment of Pilot eligibility consistent with the requirements of *Section V.B.3. Member Engagement*.
 1. The PHP shall submit outreach materials to the Department for review and approval prior to distributing materials to Members.
 - b) The PHP shall submit to the Department for review and approval a Healthy Opportunities Pilot Member Outreach Plan no later than January 15, 2022.
 - c) At least quarterly, the PHP shall proactively identify potential Pilot enrollees as part of their population health management capabilities and care management risk scoring and stratification processes, including through:
 1. Claims/encounter data;
 2. 834 files;

3. Admission, Discharge, Transfer (ADT) feed information;
4. Care management systems;
5. Provider-reported Z codes;
6. Enrollment in other programs that may serve as a proxy for Pilot eligibility (e.g., care management for high-risk pregnancy or at-risk children); and
7. Other methods as available to each PHP.

h. 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, xiii. is revised and restated as follows:

- xiii. For potential Pilot enrollees who are not already enrolled in the Pilot or who have not already started the Pilot eligibility assessment and service recommendation process, the PHP shall:
- a) Notify the Member’s care management team within ten (10) Business Days of receiving a request to assess the Member for Pilot eligibility and direct the Member’s care management team to initiate the PESA as required in *Section V.C.8.g.xxiv. Pilot Eligibility and Service Assessment* and according to *Attachment M. 12. Healthy Opportunities Implementation Schedule*.
 1. If the Member does not currently have an assigned care management team, the PHP shall conduct the initial PESA according to *Attachment M. 12. Healthy Opportunities Implementation Schedule*.
 2. If the PHP determines that the Member is eligible for Pilot services, the PHP shall ensure that the Pilot enrollee is enrolled into Care Management either with the PHP or the Designated Pilot Care Management Entity as defined in the Contract.
 - b) Ensure that the Member’s care management team:
 1. Undertakes best efforts to conduct outreach to the Member regarding the PESA within three (3) Business Days of receiving a request from a PHP, provider, HSO, Member, or Member’s authorized representative to assess the Member for Pilot eligibility.
 - i. All outreach attempts shall be documented by the care management team within NCCARE360.
 - ii. The Department defines “best efforts” as including at least two documented follow up attempts to contact the Member if the first attempt is unsuccessful.
 2. Utilizes tools such as social drivers of health (SDOH) screenings, Comprehensive Assessments, other evidence-based assessment tools, and findings from regular care management check-ins with Members to identify Pilot-eligible individuals.
 3. Builds in opportunities for assessing Members’ Pilot eligibility at additional checkpoints with Members including:
 - i. Transitions of care;
 - ii. Pregnancy and postpartum period;
 - iii. Regular care manager check-ins; and
 - iv. When a Member's circumstances or needs change significantly.

i. 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, is revised to add the following:

xxiii. Pilot Program Eligibility Criteria

- a) The PHP shall comply with the following Pilot program eligibility criteria:
 1. Member must reside in North Carolina;
 2. Member must be enrolled in a PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members;
 3. Member must live in a Pilot region, as defined by Department and in Network Lead contracts; and
 4. Member must have both:
 - i. A qualifying physical or behavioral health criteria as specified in the Department's Healthy Opportunities Pilot Care Management Protocol; and
 - ii. A qualifying social risk factor as specified in the Department's Healthy Opportunities Pilot Care Management Protocol.
- b) The PHP shall ensure that the care management team assesses potentially Pilot-eligible Members for Pilot program eligibility, including qualifying physical/behavioral health qualifying criteria and social risk factor(s) as required in *Section V.C.8.g.xxiv. Pilot Eligibility and Service Assessment*.
- c) If the Department makes changes to Pilot eligibility criteria, it will notify the PHP in writing about proposed changes and allow the PHP to comment at least thirty (30) Calendar Days prior to submitting the eligibility changes to CMS for approval. Upon approval by CMS of changes to Pilot eligibility criteria, the Department would provide the PHP with at least thirty (30) Calendar Day notice prior to requiring changes to be in effect.

xxiv. Pilot Eligibility and Service Assessment (PESA)

- a) The PHP and its Designated Pilot Care Management Entities shall use NCCARE360 to document standardized information regarding a Member's Pilot eligibility and services, including each Member's:
 1. Contact information;
 2. Health plan;
 3. Care manager of record;
 4. Physical/behavioral health and social risk factors supporting Pilot program eligibility;
 5. Recommended Pilot services;
 6. Service-specific eligibility criteria for recommended Pilot services;
 7. Indication of consent, using a Department-standardized consent form, for:
 - i. Pilot participation,
 - ii. Pilot evaluation, and
 - iii. Sharing personal information for the purpose of Pilot participation;
 - iv. Required documentation for specific services, if needed; and
 - v. PHP decision and rationale on Pilot eligibility determination and service authorization.
- b) The PHP shall limit access to the Member's Pilot-specific information in NCCARE360 to only those staff that require access.
- c) Assessing for Pilot Eligibility and Recommending Pilot Services
 1. The PHP shall ensure that the Member's care management team, by using NCCARE360:
 - i. Uses the Department-standardized PESA to assess and document a Member's Pilot program eligibility (based on the Pilot program eligibility criteria outlined in this Section), Pilot service-level eligibility outlined in the Healthy Opportunities Pilot Fee Schedule, and recommended Pilot services based on the Healthy Opportunities Pilot Fee Schedule.

- ii. Documents, where appropriate, Member preferences for, and relationships with, particular HSOs.
 - iii. Completes the PESA for a Member's initial Pilot eligibility assessment and service recommendations and updates the Member's PESA any time there is a change to the Member's Pilot service needs or eligibility.
 - iv. Uses the PESA as the assessment and documentation tool for the Member's three (3) month Pilot service mix review and six (6) month Pilot eligibility reassessment as required in *Section V.C.8.g.xxix. Pilot Service Mix and Eligibility Reassessment*.
 - v. Submits the PESA within NCCARE360 to transmit the data to the Member's PHP for eligibility and service authorization.
- d) Obtaining Pilot Consent
- 1. The PHP shall ensure the care management team obtains the following consents from the Member, using a Department-standardized template, prior to authorizing services for the Member and considering the Member enrolled in the Pilot:
 - i. Consent to receive Pilot services, including an understanding that Pilot services are neither Medicaid benefits nor an entitlement and may be revoked at any time.
 - ii. Consent to have the Member's personal data, including personal health information, shared with relevant entities involved in the Healthy Opportunities Pilot, including:
 - a) The University of North Carolina Sheps Center for Health Services Research for use in the evaluation of the Pilot; and
 - b) Organizations in the NCCARE360 network, subject to NCCARE360's privacy and security permissions.
 - 2. The PHP shall ensure that the care management team:
 - i. Obtains all required Pilot-related consents from the Member, using a Department-standardized template prior to submitting the PESA and referring the Member to Pilot services.
 - ii. Documents in NCCARE360 that the Member has provided all required Pilot-related consents listed in this Section and uploads the consent form into NCCARE360.
 - iii. Provides a copy of the consent to the Member (in person, electronically, or by mail) upon request.
 - iv. Explains that the Member will not have Pilot services reimbursed by the PHP if a Member does not provide the required consents.
 - 3. The PHP shall disenroll Member from Pilot and discontinue payment of Pilot services if a Member revokes consent as required in *Section V.C.8.g.xxix. Pilot Service Mix and Eligibility Reassessment*.
 - 4. If a Member disenrolls from the Pilot and then later re-enrolls, the PHP shall ensure that consent is obtained each time the Member re-enrolls in the Pilot.
- e) Pilot Eligibility Determination
- 1. Within NCCARE360, the PHP shall accept recommendations from a Member's care management team that the Member is eligible for the Pilot.
 - 2. The PHP shall verify that a Member is eligible for the Pilot program based on the Pilot eligibility criteria outlined in *Section V.C.8.g.xxiii. Pilot Program Eligibility Criteria*.
 - 3. The PHP shall verify within NCCARE360 that the Member has provided all consents required to participate in the Pilot and store the Member's consents.
 - 4. If NCCARE360 is missing information related to the eligibility determination, the PHP shall work with the Member's care management team to attempt to obtain the missing information.
 - 5. The PHP shall not deny Pilot eligibility based on missing information without first attempting to obtain the missing information at least three (3) times from either the

- assigned care management team, or of the Member does not have an assigned care management team, from the Member or the Member's authorized representative.
6. The PHP shall document the results of the Pilot eligibility determination in NCCARE360, including rationale if the Member is deemed not eligible.
 7. The PHP shall ensure that if a Member is found ineligible for Pilot service(s), the Member's care management team (1) will continue to provide care management or care coordination to the Member, as appropriate, and (2) will refer the Member to non-Pilot services to meet the Member's need(s).
- f) Pilot Service Authorization
1. Within NCCARE360, the PHP shall review the care management team's recommended Pilot services for a Member and verify whether the Member is eligible for the recommended Pilot service(s).
 - i. The PHP shall verify that the Member meets the Pilot service-specific eligibility criteria as articulated in the Healthy Opportunities Pilot Fee Schedule.
 - ii. The PHP shall review any required documentation or narrative for Pilot services in NCCARE360 if required by the Healthy Opportunities Pilot Fee Schedule (e.g., Member attestation of enrollment in SNAP or recent determination of SNAP ineligibility for a healthy food box).
 2. Within NCCARE360, the PHP shall authorize or deny Pilot service(s) for the Member.
 - i. The PHP shall take into account the care management team's recommendation(s), Member information on file with the PHP, and the PHP's remaining budget within the capped allocation of Pilot service funds when deciding whether to authorize or deny a Pilot service.
 - ii. In an attempt to ensure that Pilot funds are the payer of last resort, the PHP shall make best efforts to validate that no other federal, State or local service, resource or program is available and would better meet the Member's needs at the time of service authorization. The PHP may rely on Member attestation for validation.
 - iii. The PHP shall make best efforts to validate that Pilot services do not displace or duplicate other services, resources or programs for which the Pilot enrollee is eligible.
 - iv. If NCCARE360 is missing information needed for Pilot service authorization, the PHP shall attempt at least three (3) times to obtain the missing information prior to denying services. If the Member has an assigned care management team, the PHP shall work with the care management team to attempt to obtain the missing information. If the Member does not have an assigned care management team, the PHP shall work with the Member or the Member's authorized representative to obtain the missing information.
 3. The PHP shall document Pilot service authorization or denial in NCCARE360, along with rationale if the service(s) is denied.
 4. The PHP shall adhere to Department-standardized timeframes for authorization or denial of all Pilot services in accordance with *Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization*.
 5. In cases where the PHP denies a Pilot service, the PHP shall ensure that the Member's care management team continues care management or care coordination for the Member, as appropriate, and refers the Member to other Pilot or non-Pilot services to meet the Member's need(s).
 6. The PHP shall reassess a Member's eligibility for the Pilot program or a Pilot service when a care management team or Member requests to have the Member's eligibility status

reassessed in the case that the Member was determined ineligible and there is an indication the Member's health status or social risk factors have changed.

7. The PHP shall communicate the process for Members to request a reassessment of Pilot eligibility and needed services via the Member service denial notice.
8. Upon receipt of the Advanced Pilot Functionality (APF) enrollment roster from Unite Us, the PHP shall begin providing written notice using the Department-developed template to Members on decisions related to denial(s) of Pilot services as specified below:
 - i. Within five (5) Calendar Days of a decision by the PHP to not authorize Pilot service(s), the PHP shall provide written notice to the Member. The Member notice shall, at a minimum, provide the following information:
 - a) The name of Pilot service(s) denied;
 - b) The basis for the denial;
 - c) Clarification that the Member is still enrolled in Medicaid, eligible to receive care coordination or care management, and be referred to non-Pilot services;
 - d) The process to file a Healthy Opportunities Pilot grievance; and
 - e) The opportunity and process to request a reassessment for Pilot services if the Member's health status or social risk factors change.

xxv. Pilot Enrollment

- a) The PHP shall consider the Member to be a Pilot enrollee once:
 1. The PHP has verified that the Member is eligible for the Pilot program, and
 2. The PHP has authorized at least one Pilot service for the Member.
- b) The PHP shall follow the NCCARE360 work queue to document Pilot enrollment in NCCARE360 according to the Healthy Opportunities Pilot Enrollment Roster Companion Guide.
- c) The PHP shall not communicate to the Pilot enrollee about Pilot enrollment so as to not cause potential Member confusion with Medicaid eligibility or Medicaid Managed Care enrollment. The PHP shall communicate to the Pilot enrollee about Pilot service authorization(s) as specified in this Section.
- d) The PHP shall monitor the Pilot enrollee's enrollment, including when Pilot enrollment began and when the Pilot enrollee is due for a three (3) month Pilot service mix review and a six (6) month Pilot eligibility reassessment.

xxvi. Referral to Authorized Pilot Services and Care Management

- a) The PHP shall ensure that each Pilot enrollee is also enrolled in care management, is assigned to a care management team, and receives comprehensive care management that integrates Pilot services with care management for physical/behavioral health needs.
- b) The PHP shall ensure that the care management team:
 1. Informs the Pilot enrollee about authorized or denied Pilot services within two (2) Business Days of receiving PHP authorization.
 2. Makes referrals to Pilot-participating HSOs for authorized Pilot services using NCCARE360 within two (2) Business Days of receiving PHP authorization.
 - i. Referrals for Pilot services cannot be sent to HSOs until the care management team receives a service authorization from the PHP through NCCARE360, unless the service is a passthrough (also known as pre-approved Pilot services) Pilot Service.
 - ii. The PHP shall monitor receipt of invoices from HSOs to ensure that Pilot referrals are occurring, and that Pilot services are being delivered in a timely manner.

3. Includes a referral to an HSO for case management with any referral for a Pilot service that requires case management according to the service descriptions in the Healthy Opportunities Pilot Fee Schedule, e.g., home accessibility and safety modifications, one-time payment for security deposit and first month's rent.
4. Understands the option to send a referral to a particular Pilot-participating HSO or send the referral to all relevant Pilot-participating HSOs using NCCARE360 functionality.
5. Follows-up with the HSO if the referral is not accepted within two (2) Business Days of the referral being sent using NCCARE360 and elevates the issue to the appropriate Network Lead as required, as data is available through operational reporting and within UniteUs dashboards.
6. When an HSO accepts a referral:
 - i. Informs the Pilot enrollee of the accepted Pilot service referral; and
 - ii. Tracks Pilot services delivered to the Pilot enrollee and coordinates with HSO(s) regarding enrollee progress, as needed.
7. Incorporates the Pilot enrollee's Pilot service needs and services received into their care plan.
8. Escalates any Pilot network issues to both the PHP and the Network Lead as appropriate (e.g., if the care management team is not able to identify an HSO that is able to accept the referral).

xxvii. Delivery of Pilot Services

- a) Once an HSO begins providing Pilot service(s) to a Pilot enrollee, the PHP shall ensure that the care management team:
 1. Coordinates with the HSO that accepted the referral to track the outcomes of authorized Pilot service(s) and ensure Pilot service(s) are meeting the enrollee's needs, as needed.
 2. Updates the Pilot service delivery outcome(s) in the Pilot enrollee's care plan.

xxviii. Expedited Referral to Pre-Approved Pilot Services

- a) The PHP shall permit a care management team to refer eligible Pilot enrollees to passthrough Pilot services (also known as pre-approved Pilot services) for a passthrough period of thirty (30) Calendar Days without PHP authorization.
- b) Passthrough Pilot services shall include:
 1. Fruit and Vegetable Prescription;
 2. Healthy Food Box (For Pick-Up);
 3. Healthy Food Box (Delivered);
 4. Healthy Meal (For Pick-Up);
 5. Healthy Meal (Home Delivered);
 6. Reimbursement for Health-Related Public Transportation; and
 7. Reimbursement for Health-Related Private Transportation.
- c) The PHP shall ensure that the care management team:
 1. Documents a Pilot enrollee's eligibility and service-specific eligibility within NCCARE360 for passthrough Pilot services.
 2. Submits a request for authorization to the PHP using the PESA in NCCARE360 for passthrough Pilot services.
 - i. If applicable, recommends an additional duration of the service beyond the passthrough period, indicating that the Member is provisionally enrolled in the Pilot and pre-authorized to receive a Pilot service for passthrough period of up to thirty (30) Calendar Days in NCCARE360.

3. Refers the Member to a Pilot-participating HSO for a passthrough period of up to thirty (30) Calendar Days.
 - i. The care management team does not need to receive service authorization from the PHP prior to making a referral for passthrough Pilot services.
 4. Does not refer more than one passthrough period for each passthrough service per Pilot enrollee, per Pilot enrollment period.
 5. If the PHP authorizes the Member to receive additional Pilot services beyond the initial passthrough period, the care management team shall:
 - i. Generate a referral to the same HSO, if possible, or to a different HSO to deliver the remaining Pilot services past the initial passthrough period.
 - ii. Communicate to the Member that they are authorized to receive the full duration of the Pilot service recommended.
 6. If the PHP does not authorize a Member to receive additional Pilot services beyond the initial passthrough period, the care management team shall:
 - i. Not issue another referral for the remaining Pilot services past the initial passthrough period.
 - ii. Communicate to the HSO that it should stop invoicing for the Pilot service after the initial passthrough period.
 - iii. Communicate to the Member that the Pilot service is not authorized past the initial passthrough period and refer the Member to other non-Pilot services to meet their needs.
- d) The PHP shall review the care management team's PESA documentation in NCCARE360 to verify or deny the Member's Pilot eligibility and authorize or deny the continuation of passthrough Pilot services beyond the thirty (30) Calendar Day passthrough period within ten (10) Business Days of receiving the PESA from the Member's care management team through NCCARE360.
 - e) If the PHP authorizes the continuation of passthrough Pilot services past the initial passthrough period, the PHP shall document the authorization of services from the PESA and Pilot enrollment in NCCARE360.
 1. The date of Pilot enrollment shall be equivalent to the date of the referral generated by the care management team that began the passthrough period.
 - f) If PESA is missing any required information, the PHP shall work with the care management team to attempt to obtain it.
 - g) If the PHP does not authorize passthrough Pilot service(s) past the initial thirty (30) Calendar Day passthrough period:
 1. The PHP shall update NCCARE360 to reflect that the service is not authorized beyond the passthrough period;
 2. The PHP shall ensure that the care management team refers the Member to other appropriate non-Pilot service(s) to meet their needs; and
 3. The PHP shall pay for Pilot services that have been delivered during the passthrough period using Pilot service delivery funds from its capped allocation.
 - h) The PHP shall not add additional authorization or oversight processes on care management teams for passthrough Pilot services above and beyond those required by the Department.
 - i) The PHP shall have the ability to address a Designated Pilot Care Management Entity's ability to refer Members to passthrough Pilot services if the Designated Pilot Care Management Entity is found to have a pattern of approving passthrough services to Members that are subsequently found to be ineligible for the Pilots or if the PHP runs out of Pilot funds.

1. The PHP shall address the issue first by leveraging any existing notification and/or corrective action plan process the PHP typically uses with Designated Pilot Care Management Entities.
 2. If unsuccessful, the PHP may rescind the Designated Pilot Care Management Entity's ability to refer passthrough Pilot services and notify the Department to limit the Designated Pilot Care Management's access to passthrough services, as appropriate.
- xxix. Pilot Service Mix and Eligibility Reassessment
- a) The PHP shall ensure that the care management team:
 1. Tracks when the Pilot enrollees it manages care for require Pilot service mix and eligibility reassessments.
 2. Makes best efforts¹³ to schedule a reassessment with identified Pilot enrollees to occur within thirty (30) Calendar Days of the due date.
 - i. Service mix and eligibility reassessments may be completed in-person, telephonically, or by video (in compliance with any applicable state or federal laws).
 3. Reviews all available data on the Pilot enrollee in preparation for the reassessment. Conducts a reassessment of each of its Pilot enrollee's Pilot service mix at least every three (3) months.
 4. Assesses the enrollee to understand if current Pilot services are meeting the Member's needs.
 5. Utilizes the Department's standardized Healthy Opportunities screening questions and/or other assessments to evaluate if the Pilot enrollee needs additional Pilot services, including in other domains.
 6. Discontinues a Pilot service if it is no longer meeting the Member's needs.
 7. Recommends additional Pilot services for the Member to the Member's PHP if needed.
 8. Conducts a reassessment of each of its Pilot enrollee's Pilot eligibility at least every six (6) months.
 - i. Recommends the Member's disenrollment from the Pilot to the Member's PHP if the Member is no longer eligible.
 9. Documents the results of the service mix and eligibility reassessments, including by:
 - i. Documenting and transmitting outcomes of the reassessments to the Member's PHP via NCCARE360.
 10. Makes monthly attempts to conduct the reassessment following the original date if not completed on time.
 - i. Recommends the Member's disenrollment from the Pilot to the Member's PHP if Member has not completed a reassessment within six (6) months of the last reassessment, whether the last reassessment is of service mix or eligibility.
 11. Makes best effort to communicate the discontinuation of any Pilot services with the Member and identifies other Pilot or non-Pilot services to meet the Member's needs.

¹³ The Department defines "best efforts" as including at least two documented follow up attempts to contact the Member if the first attempt is unsuccessful.

- b) Upon receiving results of a Member’s reassessment from the care management team via NCCARE360, the PHP shall authorize or deny any new recommended Pilot services and any changes to Pilot eligibility or enrollment, as appropriate, in NCCARE360.
 - 1. The following circumstances can result in Pilot disenrollment:
 - i. The Member is no longer eligible for the Pilot program or any Pilot service as described in *Section V.C.8.g.xxiii. Pilot Program Eligibility Criteria*;
 - ii. The Member is no longer authorized to receive any Pilot service;
 - iii. The Member has neither responded to an outreach for, nor completed, either a service mix or eligibility reassessment within six (6) months of the last assessment ;
 - iv. The Member’s needs have been met and the Member no longer requires Pilot service(s); and
 - v. The PHP has expended all available Pilot service delivery funds.
 - c) The PHP is not required to conduct or allow a reassessment if the PHP has dispersed all of their capped allocation for that Pilot Year.
- xxx. The PHP shall update their Care Management Policy to include the PHP’s approach to meet the requirements of this Section. The PHP shall submit the Policy for review and approval by the Department upon request.
- xxxi. Quality Improvement and Pilot Program Evaluation
- a) The PHP shall collaborate with Network Leads regularly and at reasonable request of the Network Lead to support Network Leads’ development of training, technical assistance and convenings and to support Network Leads’ requirements to improve HSO performance.
 - b) The PHP shall provide timely and accurate reports to the Department on regular intervals as noted in *Attachment J: Third Revised and Restated Reporting Requirements* to support:
 - 1. Pilot program evaluation;
 - 2. Department reporting to CMS; and
 - 3. Department efforts to monitor, evaluate, and improve Pilot program implementation.
 - c) The PHP shall submit timely, complete, accurate data to the Department as required in *Section V.K.8. Healthy Opportunities Pilots*. The PHP’s data submissions shall conform to all Department requirements regarding:
 - 1. Data elements contained in the data submission;
 - 2. File format, including any requirements that specific data be submitted in a machine-readable format and include accompanying metadata;
 - 3. Cadence and timeliness of data submission;
 - 4. Data completeness, accuracy, or any other components of data quality or integrity;
 - 5. Data privacy and security standards and processes; and
 - 6. Data governance policies, processes, and controls.
- xxxiii. Capped Allocation Funding
- a) The PHP shall develop a comprehensive Capped Allocation Funding Management Policy that outlines the PHP’s approach to use the capped allocation payments described in *Section III.D.32. PAYMENT AND REIMBURSEMENT*. The PHP shall submit the Policy for review and approval by the Department upon request.
 - b) The capped allocation provided to the PHP will include funding for all Pilot regions. The Department will communicate to the PHP the amount of funding that shall be distributed in each Pilot region in the Department’s Healthy Opportunities Pilot Payment Protocol.
 - 1. The PHP shall make a good faith effort to utilize capped allocation resources for each Pilot region as directed by the Department.

2. The PHP shall submit information to the Department, upon request, if the PHP's regional Pilot spending differs from the regional capped allocations provided by the Department. If the PHP's regional Pilot spending varies more than ten percent (10%) from the regional capped allocations provided by the Department, the PHP shall adjust its regional spending at the Department's request.

j. Section V.D. Providers, 1. Provider Network, c. Availability of Services (42 C.F.R. § 438.206) is revised to add the following:

- vi. Relationship between the PHP and Network Lead for the Healthy Opportunities Pilots
 - a) The PHP shall contract with any Healthy Opportunities Network Lead operating in the PHP's Region(s), as specified in *Section V.C.8, g. Healthy Opportunities Pilot* and 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).
 1. The PHP shall not amend the Department-standardized PHP-Network Lead model contract except as required by the Department.
 2. The PHP shall not contract directly with HSOs for the purposes of Pilot program activities for the duration of the Pilot program.
 - b) The PHP shall not be required to compensate Network Leads for responsibilities related to the Pilot program.
 - c) The PHP shall execute business associate agreement with each Network Lead using a Department-defined template.

k. Section V.D.5. Provider Grievances and Appeals is revised to add the following:

- j. HSO Grievances related to the Healthy Opportunities Pilot
 - i. The PHP shall allow an HSO to file a grievance related to Healthy Opportunities Pilot Services with the PHP or through the HSO's Network Lead.
 - ii. Pilot-related HSO grievances may include:
 - a) HSO grievances related to Pilot service payment, including:
 1. Payment disputes for denied Pilot service invoices;
 2. Payment errors; and
 3. Overpayments or underpayments due to fraud, waste, or abuse.
 - iii. The PHP shall handle HSO grievances related to the Healthy Opportunities Pilot promptly, consistently, fairly, and in compliance with requirements in this Section.
 - iv. The PHP shall submit a Healthy Opportunities Pilot Provider Grievance Policy to the Department for review and approval upon request.
 - v. Notices
 - a) The PHP shall permit Pilot-related HSO grievances to be filed with the PHP or HSO's Network Lead within thirty (30) Calendar Days of the issue causing the grievance.
 - b) The PHP shall acknowledge receipt of each grievance with the HSO and Network Lead within five (5) Calendar Days of receipt of the grievance from the HSO or the HSO's Network Lead.
 - c) The PHP shall provide notice of the outcome of the grievance to the HSO and the HSO's Network Lead within thirty (30) Calendar Days of receiving a grievance.

l. Section V.J. Compliance, 1. Compliance Program is revised to add the following:

- d. Healthy Opportunities Pilot Compliance Program
 - i. If the PHP identifies a significant performance issue or program integrity issue with an HSO, the PHP shall notify the Network Lead within three (3) Business Days to enable the Network Lead to conduct HSO performance improvement activities consistent with the PHP-Network Lead and Network Lead-HSO model contracts.

- a) For the purposes of this Section, a significant performance issue is defined as three (3) or more incidents within three (3) months of failures to comply with material Pilot program requirements.
 - b) For the purposes of this Section, a program integrity issue is defined as one incident that would likely affect the health or safety of a Pilot Enrollee or inappropriate management of pilot funding.
- ii. In the event that the PHP identifies a significant performance issue or program integrity issue with an HSO, the PHP shall notify the Network Lead within three (3) Business Days to enable the Network Lead to conduct an investigation.
- iii. In the event of verified performance issue or program integrity issue identified by the Network Lead during the investigation results in suspension or termination of the HSO from its network, the PHP shall:
 - a) Stop payment to the HSO within one (1) Business Day of notification of suspension or termination by the Network Lead or Department.
 - b) Begin payment, as owed, to the HSO within three (3) Business Days if suspension is lifted at the direction of the Network Lead or Department.
- iv. The PHP's contracted Network Lead shall make best efforts to facilitate resolution of overpayments consistent with the Department-Network Lead Contract, the PHP-Network Lead model contract, and the Network Lead-HSO Contract. In the event of an overpayment identified by the Network Lead or Department to an HSO, the HSO shall return payment to the PHP or Department, at the Department's sole discretion, as facilitated by the Network Lead.
- v. The PHP shall have the right, to inspect, during normal business hours, Network Lead's records related to pilot service provision by HSOs, or Network Lead's obligations under the PHP-Network Lead contract. The PHP shall provide at least thirty (30) Calendar Day advance notice to the Network Lead and shall limit the inspection to purposes related specifically to obligations of the Network Lead to the PHP and as applicable to PHP-Network Lead contract.

m. Section V.J. Compliance, 3. Fraud, Waste, and Abuse Prevention is revised to add the following:

- f. Healthy Opportunities Pilot Fraud, Waste, and Abuse Prevention
 - i. The PHP's contracted Network Lead shall make best efforts to facilitate resolution of overpayments or underpayments due to fraud, waste and abuse between the PHP and HSOs consistent with Department-Network Lead Contract, the PHP-Network Lead model contract, and the Network Lead-HSO Contract.
 - ii. In the event of an underpayment identified by the Network Lead to an HSO due to fraud, waste or abuse, the PHP shall make a payment to the HSO in the amount it is owed.
 - iii. In the event of an overpayment identified by the Network Lead to an HSO due to a finding of fraud, waste or abuse, the HSO shall return payment to the PHP or Department, at the Department's sole discretion, as facilitated by the Network Lead.

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

Section VI.A. Contract Violations and Noncompliance, *Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages* is revised and restated in its entirety as follows:

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
1.	Failure to meet plan readiness review deadlines as set by the Department.	\$5,000 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in <i>Section V.A.9. Staffing and Facilities</i> and <i>Attachment O. 10. Disclosure of Conflicts of Interest</i> .	\$10,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by <i>Attachment O.9. Disclosure of Litigation and Criminal Conviction</i> .	\$1,000 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in <i>Attachment O.9. Disclosure of Ownership Interest</i> .	\$2,500 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in <i>Section V.B.4. Marketing</i>	\$5,000 per occurrence
6.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in <i>Section V.B.2. Medicaid Managed Care Enrolment and Disenrollment</i> .	\$500 per occurrence per Member
7.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in <i>Section V.B.3. Member Engagement</i> .	\$250 per occurrence per Member
8.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in <i>Section V.B.6. Member Grievances and Appeals</i> .	\$500 per occurrence
9.	Reserved.	Reserved.
10.	Failure to comply with all orders and final decisions relating to claim disputes, appeals and/or State Fair Hearing as issued or as directed by the Department.	\$5,000 per occurrence

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
11.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in <i>Section V.B.6. Member Grievances and Appeals.</i>	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND \$500 per Calendar Day for each day the PHP fails to provide continuation or restoration as required by the Department.
12.	Failure to attend mediations and hearings as scheduled as specified in <i>Section V.B.6. Member Grievances and Appeals.</i>	\$1,000 for each mediation or hearing that the PHP fails to attend as required
13.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	\$5,000 per occurrence per Member
14.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified <i>Section V.C.1. Medical and Behavioral Health Benefits Package and V.C.3. Pharmacy Benefits.</i>	\$5,000 per standard authorization request \$7,500 per expedited authorization request
15.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified <i>Section V.D.1. Provider Network.</i>	\$1,000 per occurrence
16.	Failure to follow Department required Clinical Coverage Policies as specified <i>Section V.C.1. Medical and Behavioral Health Benefits Package.</i>	\$2,500 per occurrence
17.	Failure to timely update pharmacy reimbursement schedules as required by as specified <i>Section V.C.3. Pharmacy Benefits.</i>	\$2,500 per Calendar Day per occurrence
18.	Failure to comply with Transition of Care requirements as specified <i>Section V.C.4. Transition of Care.</i>	\$100 per Calendar Day, per Member AND The value of the services the PHP failed to cover during the applicable transition of care period, as determined by the Department.
19.	Failure to ensure that a Member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified <i>Section V.C.5. Non-Emergency Transportation.</i>	\$500 per occurrence per Member
20.	Failure to comply with driver requirements as defined in the PHP NEMT Policy.	\$1,500 per occurrence per driver

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
21.	Failure to comply with the assessment and scheduling requirements as defined in the PHP NEMT Policy.	\$250 per occurrence per Member
22.	Failure to comply with vehicle requirements as defined in the PHP NEMT Policy.	\$1,500 per Calendar Day per vehicle
23.	Failure to timely develop and furnish to the Department PHP the Care Management Policy.	\$250 per Calendar Day
24.	Reserved.	Reserved.
25.	Reserved.	Reserved.
		Reserved.
		Reserved.
26.	Reserved.	Reserved.
27.	Reserved.	Reserved.
28.	Reserved.	Reserved.
29.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with a LHD.	\$500 per Calendar Day
30.	Failure to implement and maintain an Opioid Misuse Prevention Program as described in <i>Section V.C.7. Prevention and Population Health Management Program.</i>	\$2,000 per Calendar Day for each day the Department determines the PHP is not in compliance with the Opioid Misuse Prevention Program requirements
31.	Failure to update online and printed provider directory as required by <i>Section V.D.2. Provider Network Management.</i>	\$1,000 per provider, per Calendar Day
32.	Failure to report notice of provider termination from participation in the PHP's provider network (includes terminations initiated by the provider or by the PHP) to the Department or to the affected Members within the timeframes required by <i>Section V.D.2. Provider Network Management.</i>	\$100 per Calendar Day per Member for failure to timely notify the affected Member
33.	Reserved.	Reserved.
34.	Failure to notify a provider of the network contracting decision within five (5) Business Days of verification of the provider's status as a Medicaid Enrolled provider.	\$50 per Calendar Day per provider
35.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in <i>Section V.D.1. Provider Network (excludes Department approved exceptions to the network adequacy standards).</i>	\$2,500 per month for failure to meet any of the listed standards, either individually or in combination
36.	Failure to timely submit a PHP Network Data File that meets the Department's specifications.	\$250 per Calendar Day

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
37.	Failure to maintain accurate provider directory information as required by <i>Section V.D.2. Provider Network Management.</i>	\$100 per confirmed incident
38.	Failure to timely provide notice to the Department of capacity to serve the PHP's expected enrollment as described in <i>Section V.D.1. Provider Network.</i>	\$2,500 per Calendar Day
39.	Failure to submit quality measures including audited HEDIS results within the timeframes specified in <i>Section V.E.1. Quality Management and Quality Improvement.</i>	\$5,000 per Calendar Day
40.	Failure to timely submit appropriate PIPs to the Department as described in <i>Section V.E.1. Quality Management and Quality Improvement.</i>	\$1,000 per Calendar Day
41.	Failure to timely submit QAPI to the Department as described in <i>Section V.E.1. Quality Management and Quality Improvement.</i>	\$1,000 per Calendar Day
42.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in <i>Section V.A.3. National Committee for Quality Assurance (NCQA) Association.</i>	\$100,000 per month for every month beyond the month NCQA accreditation must be obtained
43.	Failure to timely submit monthly encounter data set certification.	\$1,000 per Calendar Day
44.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in <i>Attachment J: Third Revised and Restated Reporting Requirements.</i>	\$2,000 per Calendar Day
45.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in <i>Section V.I.2 Medical Loss Ratio and Attachment J. Third Revised and Restated Reporting Requirements.</i>	\$2,000 per Calendar Day
46.	Failure to timely and accurately submit monthly financial reports in accordance with <i>Attachment J: Third Revised and Restated Reporting Requirements</i> or comply with any other ad-hoc request for financial reporting as directed by the Department.	\$1,000 per Calendar Day
47.	Failure to establish and maintain a Special Investigative Unit as described in <i>Section V.J.3. Fraud, Waste and Abuse Prevention.</i>	\$5,000 per Calendar Day that the Department determines the PHP is not in compliance

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
48.	Failure to timely submit on an annual basis the Compliance Program report as described in <i>Section V.J.1. Compliance Program</i> and <i>Attachment J: Third Revised and Restated Reporting Requirements</i> .	\$1,000 per Calendar Day
49.	Failure to timely submit the Recoveries from Third Party Resources Report described in <i>Section V.J.4. Third Party Liability</i> and <i>Attachment J: Third Revised and Restated Reporting Requirements</i>	\$250 per Calendar Day
50.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	\$2,500 per incident for failure to fully cooperate during an investigation
51.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PHP's own conduct, a provider, or a Member.	\$250 per Calendar Day
52.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in <i>Section V.J.3. Fraud, Waste and Abuse Prevention</i> and <i>Attachment J: Third Revised and Restated Reporting Requirements</i> .	\$2,000 per Calendar Day
53.	Failure by the PHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	\$500 per Member per occurrence per AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the PHP's failure to comply with the terms of this Contract, the PHP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
54.	Failure by the PHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	\$500 per Member per occurrence

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
55.	Failure by the PHP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	\$500 per Member per occurrence, not to exceed \$10,000,000
56.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	\$500 per Calendar Day that the Department determines the PHP is not in compliance
57.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	\$1,000 per occurrence per committee that the Department determines the PHP is not in compliance
58.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	\$500 per Calendar Day the unapproved agreement or materials are in use
59.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	\$1,500 per occurrence per plan/program that the Department determines the PHP is not in compliance
60.	Failure to provide a timely and acceptable corrective action plan or comply with a corrective action plan as required by the Department.	\$500 per Calendar Day for each day the corrective action plan is late, or for each day the PHP fails to comply with an approved corrective action
61.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	\$500 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
62.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	\$1,000 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
63.	Failure to implement and maintain a Member Lock-In Program as described in <i>Section V.C.7. Prevention and Population Health Management Program</i> .	\$500 per calendar day per member that the PHP is not meeting Lock-In Requirements outlined in <i>Section V.C.7 Prevention and Population Health Management Program</i> and N.C. Gen. Stat. § 108A-68.2.

Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
64.	Failure to remove providers that are not actively enrolled in NC Medicaid within the PHP Network File within one (1) Business Day as specified in <i>Section V.D.2. Provider Network Management.</i>	\$1,000 per provider per business day
65.	Engaging in gross customer abuse of Members by PHP service line agents as prohibited by <i>Section V.G.1. Service Lines.</i>	\$1,000 per occurrence
66.	Failure to timely report incidents of gross customer abuse to the Department in accordance with <i>Section V.G.1. Service Lines.</i>	\$250 per Business Day the PHP fails to timely report to the Department.
67.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements in <i>Section V.C.8. Opportunities for Health.</i>	\$500 per Calendar Day that the Department determines the PHP is not in compliance beginning on or after August 1, 2022.
68.	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes as specified in <i>Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization.</i>	\$500 per Calendar Day beginning on or after September 1, 2022
69.	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes as specified in <i>Section V.D.4. Provider Payments.</i>	\$500 per Calendar Day beginning on or after September 1, 2022

4. **Modifications to Section VII. Attachments A – N of the Contract.**

Section VII. Attachment A – N is revised to add the following attachments.

- a. **Section VII. Attachment M.12. Healthy Opportunities Implementation Schedule** is incorporated into the Contract to define the Healthy Opportunities Implementation Schedule dates with the corresponding Key Steps and Description as stated in Attachment 1, *Attachment M.12. Healthy Opportunities Implementation Schedule* to this Amendment.
- b. **Section VII. Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization** is incorporated into the Contract as stated in Attachment 4, *Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization* to this Amendment.

5. Effective Date

This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

6. Other Requirements

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

Execution:

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

Department of Health and Human Services

Dave Richard, Deputy Secretary

Date: _____

PHP Name

PHP Authorized Signature

Date: _____

Attachment 1

Attachment M. 12. Healthy Opportunities Implementation Schedule

Implementation Dates	Key Steps/Description
<p>February 1, 2022: Engagement and NCCARE360 Functionality</p>	<ol style="list-style-type: none"> 1. PHP to accelerate engagement with Network Leads and HSOs. 2. Pilot/Unite Us Payments functionality to be ready in NCCARE360. NCCARE360 training environment available to PHPs from February 1, 2022 – March 15, 2022. 3. HSO onboarding status to Pilot/Unite Us Payments functionality, including services offered, to be communicated to PHPs.
<p>March 15, 2022: Launch food services and three (3) Designated Pilot Care Management Entities</p>	<ol style="list-style-type: none"> 1. PHP to launch service delivery in all Pilot regions for food services domain. 2. PHP to enroll Members into the Healthy Opportunities Pilots from three (3) Designated Pilot Care Management Entities: Access East, Mission Health Partners, and CCPN. PHP shall not be required to perform “care manager” role of assessing eligibility and recommending enrollment and services for Members assigned to Tier 1 and 2 AMHs or to Members assigned to Tier 3 AMHs. 3. The Department reserves the right to set expectations or limit Pilot enrollment for one hundred (100) – two hundred fifty (250) Members per Designated Pilot Care Management Entities in the first forty-five (45) Calendar Days.
<p>May 1, 2022: Launch housing and transportation services and additional Designated Pilot Care Management Entities</p>	<ol style="list-style-type: none"> 1. PHP to launch delivery of housing and transportation services. 2. PHP to enroll Members from additional Designated Pilot Care Management Entities, including Carolina Medical Home Network, Atlantic Medical Management, and other interested Designated Pilot Care Management Entities, subject to Care Management Entity contracting success.
<p>June 15, 2022: Launch toxic stress and cross-domain services. Launch interpersonal violence and certain cross-domain services June 15, 2022 or a later date determined by the Department.</p>	<ol style="list-style-type: none"> 1. PHP to launch delivery of toxic stress and cross-domain services. PHP to launch delivery of interpersonal violence services and certain cross-domain services June 15, 2022 or a later date determined by the Department. 2. PHP shall be required to begin “care manager” role of assessing eligibility, enrolling, and recommending services for Members assigned to Tier 1 and 2 AMHs and to Members assigned to Tier 3 AMHs not conducting Pilot care management.

Attachment 2

Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization

Domain	Pilot Service Name	Service Authorization Timelines
Housing Services	Housing Navigation, Support and Sustaining Services	Three (3) Business Days
	Inspection for Housing Safety and Quality	Seven (7) Business Days
	Housing Move-In Support	Seven (7) Business Days
	Essential Utility Set-Up	Three (3) Business Days
	Home Remediation Services	Seven (7) Business Days
	Home Accessibility and Safety Modifications	Seven (7) Business Days
	Healthy Home Goods	Seven (7) Business Days
	One-Time Payment for Security Deposit and First Month's Rent	Seven (7) Business Days
	Short-Term Post Hospitalization Housing	Three (3) Business Days

Domain	Pilot Service Name	Service Authorization Timelines
Food Services	Food and Nutrition Access Case Management Services	Seven (7) Business Days
	Evidence-Based Group Nutrition Classes	Seven (7) Business Days
	Diabetes Prevention Program	Seven (7) Business Days
	Fruit and Vegetable Prescription	Passthrough; Expedited Referral
	Healthy Food Box (For Pick-Up)	Passthrough; Expedited Referral
	Healthy Food Box (Delivered)	Passthrough; Expedited Referral
	Healthy Meal (For Pick-Up)	Passthrough; Expedited Referral
	Healthy Meal (Home Delivered)	Passthrough; Expedited Referral
	Medically Tailored Home Delivered Meal	Seven (7) Business Days

Domain	Pilot Service Name	Service Authorization Timelines
Interpersonal Violence Services	IPV Case Management Services	Seven (7) Business Days
	Violence Intervention Services	Seven (7) Business Days
	Evidence-Based Parenting Curriculum	Seven (7) Business Days
	Home Visiting Services	Seven (7) Business Days
	Dyadic Therapy	Seven (7) Business Days
Transportation Services	Reimbursement for Health-Related Public Transportation	Passthrough; Expedited Referral
	Reimbursement for Health-Related Private Transportation	Passthrough; Expedited Referral
	Transportation PMPM Add-On for Case Management Services	Seven (7) Business Days
Cross-Cutting Services	Holistic High Intensity Enhanced Case Management	Seven (7) Business Days
	Medical Respite	Three (3) Business Days
	Linkages to Health-Related Legal Supports	Seven (7) Business Days