Amendment Number 10 (11)

Contract #30-2022-007-DHB-X

Medicaid Direct Prepaid Inpatient Health Plan Contract

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

Purpose:

The purpose of this Amendment is to modify existing requirements and incorporate new requirements to the Contract as follows:

a. Modify requirements in *Section II. Definitions and Abbreviations;*

b. Modify requirements in *Section III. Contract Term, General Terms and Conditions, Protections, and Attachments;*

c. Modify requirements in *Section IV. Scope of Services*;

d. Modify requirements in *Section V. Contract Performance*; and

e. Modify *Section VI. Contract Attachments* as specified herein.

The Parties agree as follows:

I. Modifications to Section II. Definitions and Abbreviations

Specific subsections are modified as stated herein.

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

55. **Cross Area Service Program (CASP):** DMH/DD/SUS designated specialty service program that is funded by the DMH/DD/SUS through federal and/or State funds to provide targeted services to an identified population segment (e.g., pregnant women, families, etc.). A CASP is designated by the DMH/DD/SUS as a result of a critical federal grant initiative or a priority state service initiative

59. **Date of Payment**: The point in time following the Claim Adjudication Date when reimbursement is generated for services. This is either the date of Electronic Funds Transfer (EFT) or the date a paper check is mailed.

79. **Grantee:** The State government entity (i.e., NC DHHS, DMH/DD/SUS) to which a federal grant is awarded, and which is responsible and accountable for the use of the funds provided and for the performance of the grant-supported project or activity.

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

b. *Section II. A. Definitions* is revised to add the following:

226. **Competitive Integrated Employment (CIE) Data Collection Tool**: The Competitive Integrated Employment Data Collection Tool developed by the Department for purposes of gathering information regarding individuals with intellectual or developmental disabilities receiving services or any In-Lieu of Services (ILOS) inclusive of activities that promote engagement in competitive

integrated employment (CIE) or in meaningful day activities supporting competitive integrated employment.

227. **MCO CIE Stakeholder Advisory Group for CIE**: The stakeholder advisory group for competitive integrated employment opportunities for individuals with I/DD that includes representatives from each PIHP, which is facilitated by the Department.

c. *Section II. B. Abbreviations and Acronyms* is revised and restated in its entirety as follows:

59. DMH/DD/SUS: Division of Mental Health, Developmental Disabilities and Substance Use Services

d. *Section II. B. Abbreviations and Acronyms* is revised to add the following:

244. CIE: Competitive Integrated Employment
245. ADVP: Adult Developmental Vocational Program
246. CLS: Community Living and Supports
247. CCP: Continuing Care Plan
248. DCW: Direct Care Worker
249. SPMI: Severe and Persistent Mental Illness
250. TAC: Technical Assistance Collaborative

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

Specific subsections are modified as stated herein.

a. *Section III. B. General Terms and Conditions*, 1*: ACCESS TO PERSONS AND RECORDS:* is revised and restated in its entirety as follows:

1. ACCESS TO PERSONS AND RECORDS:

a. Pursuant to N.C. Gen. Stat. §§ 147-64.7 and 143-49(9), the Department, the State Auditor, appropriate State or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, and accounts of the Contractor, their Subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with **Paragraph 36. RECORDS RETENTION** of this *Section III.B* of this Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or State law and/or regulation, and the Contractor must adhere to such changes or additions.

b. The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with N.C. Gen. Stat. § 147-64.7. Nothing in this Section is intended to limit or restrict the State Auditor's rights.

c. The financial auditors of the Department shall also have full access to all of Contractor's financial records and other information determined by the Department to be necessary for the Department's substantiation of the monthly payment(s). These audit rights are in addition to any audit rights any federal agency may have regarding the use of federally allocated funds.

d. The following entities may audit the records of this Contract during and after the term of the Contract to verify accounts and data affecting fees or performance:

i. The State Auditor;

ii. The internal auditors of the affected department or agency, to the extent authorized by law; and

iii. The Joint Legislative Commission on Governmental Operations (Commission) and Commission staff, as defined in NCGS § 120-72(3), whose primary responsibility is to provide professional or administrative services to the Commission.

e. Nothing in this section is intended to limit or restrict the State Auditor's Rights.

f. This term shall survive termination or expiration of the Contract.

b. *Section III. B. General Terms and Conditions, 10: <u>COMPLIANCE WITH LAWS:</u>* is revised and restated to add the following:

f. Certifications and Representations

i. Contractor shall certify annually pursuant to 2 C.F.R. § 200.209 Certifications and Representations that it is in compliance with federal certification and representation requirements regarding Nondiscrimination, Drug-Free Workplace Requirements, Environmental Tobacco Smoke, Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions and Lobbying.

ii. Contractor shall certify annually that it is in compliance with state certification requirements regarding Verification of Employee Work Authorization, Ineligibility, Prior Convictions and Prior Employment.

c. *Section III. B. General Terms and Conditions, 11. <u>CONTRACT ADMINISTRATORS:</u>, For the Department, Contract Administrator for all contractual issues listed herein:* is revised and restated in its entirety as follows:

Name & Title	Kimberley Kilpatrick Associate Director, Managed Care Contracting
Address Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-410-5526
Fax Number	919-715-8468
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

d. *Section III. B. General Terms and Conditions, 18. <u>ENTIRE AGREEMENT AND ORDER OF PRECEDENCE</u>* is revised and restated in its entirety as follows:

18. <u>ENTIRE AGREEMENT AND ORDER OF PRECEDENCE:</u> This Contract consists of the following documents incorporated herein by reference:

a. Any amendments, business requirements, or implementation plans, executed by the Parties, in reverse chronological order; and any Contractor policies, plans, processes, procedures, strategy documents, work plans or work flows that require Department approval and have been approved, in reverse chronological order; and

b. Executed Contract.

In the event of a conflict between the Contract Documents, the document in the Contract with the highest precedence shall prevail. These documents constitute the entire agreement between the parties and supersede all prior oral or written statements or agreements.

e. ***Section III. B. General Terms and Conditions, 34. PAYMENT AND REIMBURSMENT:, j. Healthy Opportunities Pilot Program:, iv.*** **is revised and restated in its entirety as follows:**

iv. The Contractor shall return unused Pilot funds to the Department at the Department's request to reconcile the Contractor's actual Pilot spending against Pilot payments received from the Department and is required to return all unused Pilot funds to the Department at the end of the Pilot program in accordance with the Department's Healthy Opportunities Pilot Payment Protocol: Tailored Plan/ PIHPs.

f. ***Section III. B. General Terms and Conditions, 36. RECORDS RETENTION:, a.*** **is revised and restated in its entirety as follows:**

a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer or shorter period is required by federal or State law or policy. Federal record retention standards are located in 42 C.F.R. § 438.3(u). The State policy is mandated by the State Archives of North Carolina and is here: https://archives.ncdcr.gov/government.

g. ***Section III. B. General Terms and Conditions, 49. WAIVER:*** **is revised and restated in its entirety as follows:**

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

III. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

a. ***Section IV. A. Administration and Management, 1. Medicaid Program Administration, j.*** **is revised to add the following:**

viii. Managed Care Clinical Supplemental Guidance;
ix. Notice of Adverse Benefit Determination Clearinghouse Upload Instructions;
x. Healthy Opportunities Pilot Care Management Protocol: Tailored Plans/PIHPs;
xi. Healthy Opportunities Pilot Payment Protocol: Tailored Plans/PIHPs;
xii. Healthy Opportunities Pilot Transitions of Care Protocol: Tailored Plans/PIHPs;
xiii. Tailored Care Management Provider Manual Addendum: Healthy Opportunities Pilot Standard Terms & Conditions for AMH+s/CMAs;
xiv. Tailored Care Management Auto Assignment Requirements Document;
xv. Notice of Adverse Benefit Determination Guide;
xvi. Reserved;
xvii. Tailored Care Management Provider Manual;
xviii. CIE IDD Strategic Plan;
xix. NC Medicaid Managed Care Technical Specifications;
xx. North Carolina's Medicaid Quality Measurement Technical Specifications Manual.
xxi. TCL Housing Guidelines;

xxii. TCL QAPI Guidance;
xxiii. Department's TCL Implementation Plan;
xxiv. Encounter Data Submission Guide;
xxv. Encounter Data Submission Companion Guides- 837I and 837;
xxvi. Person-Centered Planning Instruction Manual;
xxvii. NCMT AMH/PCP AA Requirements Document;
xxviii. NC Medicaid Managed Care Billing Guidance to Health Plans.

b. ***Section IV. A. Administration and Management, 6. Staffing and Facilities, Section IV. A.6. First Revised and Restated Table 1: Key Personnel Requirements for the PIHP*** **is revised and restated in its entirety as follows:**

Section IV.A.6: Second Revised and Restated Table 1. Key Personnel Requirements for the PIHP				
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**	**Position May be Shared Across PIHP and BH I/DD Tailored Plan**
1.	Chief Executive Officer (CEO) of North Carolina Medicaid	Individual who has clear authority over the general administration and day-to-day business activities of this Contract Duties and Responsibilities include but are not limited to: • Appoint, supervise, and terminate area authority staff • Administer area authority services • Develop the budget of the area authority for review by the area board • Provide information and advice to the board of county commissioners through county manager • Serve as the liaison between the area authority and the department	• Must meet North Carolina residency requirements under this Contract • Must hold a Master's degree from an accredited college or university in business, healthcare administration, public health, finance, law, medicine or a related field that is deemed acceptable by the area board • Must have management experience	Yes
2.	Chief Financial Officer (CFO) of North Carolina Medicaid	Individual responsible for accounting and finance operations, including financial audit activities	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution	Yes

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

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

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

o. To support the insurance come-behind billing effort and protect the PIHP's recovery rights on billed claims, the PIHP shall submit to the Department a listing of the claims previously billed to insurance carriers or recovered by other means. This listing is referred to as a match-off file. After the initial match-off file is delivered, the subsequent frequency will be monthly. The PIHP shall deliver the initial match-off file to reflect the claims billed to insurance carriers or recovered during the period of July 1, 2024 through December 31, 2024. The PIHP shall deliver the initial match-off file to the Department by no later than March 31, 2025.

p. The monthly match-off files shall be delivered by the fifteenth (15th) day of each month and include the claims billed or recovered in the previous calendar month.

i. To support the match-off process, the match-off file should contain the following data elements:

1. DHB Recognized Medicaid Identification number;
2. From Date of Service;
3. To Date of Service;
4. Charge Amount;
5. Paid Amount;
6. Paid Date;
7. Date Billed to Carrier or Claim Recouped from Provider; and
8. Deposit date of recovery or date claim recouped from Provider.

ii. If the PIHP does not provide a match-off file or delivers the file to the Department after the due date described in this section, any resulting refunds requested by carriers will be refunded to the carrier by the PIHP.

d. ***Section IV. C. Compliance, 5. Medicaid Service Recipient Explanation of Medical Benefit (REOMB)*** **is revised to add the following:**

j. The PIHP shall submit a REOMB report quarterly, or upon request, to the Department.

e. ***Section IV. E. Members, 1. Eligibility and Enrollment for PIHPs, a. Department Roles and Responsibilities*** **is revised and restated in its entirety as follows:**

a. Department Roles and Responsibilities

i. The Department has authority to determine North Carolina Medicaid eligibility and define the populations excluded or delayed from managed care who are thereby eligible for a PIHP consistent with N.C. General Statute § 108D-40(a) and N.C. General Statute § 108D-60 as amended by S.L. 2021-64, s. 3.4A.

ii. The Department shall maintain sole authority for performing, managing, and maintaining all Medicaid eligibility, PIHP eligibility, enrollment, including but not limited to the following populations who are excluded or delayed from Medicaid Managed Care shall be eligible for enrollment in PIHP:

1. Beneficiaries who reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) Calendar Days or longer.
2. Beneficiaries who are in one of the following categories will be enrolled in the PIHP until the launch of the Foster Care Plan:
   a. Enrolled in the foster care system;
   b. Receiving adoption assistance; or
   c. Under the age of twenty-six (26) and formerly were in the foster care system.

3. Beneficiaries who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, except for beneficiaries enrolled in the Innovations waiver.
4. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations waivers excluding federally recognized tribal members
5. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the TBI waivers excluding federally recognized tribal members[1].
6. Presumptively eligible beneficiaries, during the period of presumptive eligibility, excluding presumptive eligibility for pregnant women.
7. Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations and TBI waivers.
8. Beneficiaries being served through CAP/C and
9. Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice).
10. Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a).
11. Beneficiaries who are inmates of prisons, as provided in N.C.G.S. § 108D-40(a)(9).
12. Beneficiaries who are residing in carceral settings other than prisons, as provided in N.C.G.S. § 108D-40(a)(9a).

f. ***Section IV. E. Members, 3. Member Engagement, m. Member Handbook, iii., 1.*** **is revised and restated in its entirety as follows:**

1. Covered benefits provided by the PIHP, including:
   a. Waiver services and supports where applicable;
   b. Care management and care coordination, including, for members engaged in Tailored Care Management, how to select and change care managers or the organization where they are obtaining Tailored Care Management; and
   c. Any approved In Lieu of Services and Value Added Services.

g. ***Section IV. E. Members, 3. Member Engagement, m. Member Handbook, iii., 11*****. is revised and restated in its entirety as follows:**

11. Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100, rights related to In Lieu of Services as defined in *Sections IV.F.1.g.* and *Section VI. First/Second Revised and Restated Attachment L. Policies, 7. Approved <Plan Name> In Lieu of Services* of this Contract, and any other rights and responsibilities under the Contract.

h. ***Section IV. E. Members, 6. Member Grievances and Appeals, b. Member Grievances and Appels General Requirements, viii.*** **is revised and restated in its entirety as follows:**

viii. The PIHP shall use Department developed templates for all member notices related to the member Grievance and Appeals processes that meet applicable notification standards, including but not limited to, the Notice of Adverse Benefit Determination, the plan Appeal request form, the State Fair Hearing Appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii). The Department shall provide such templates in a timely fashion and agrees to provide the PIHP with ninety (90) Calendar Days' advance notice of the issuance

[1] Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

of new templates before the templates' proposed effective date. The Department shall not issue new templates more than once a year unless required by regulatory changes. The Department shall allow the PIHP the right to provide comment and feedback on proposed template modifications, which the Department shall consider before the templates are finalized. Except as indicated in the template, the PIHP shall not modify Department developed template language provided for the purposes of notifying Members of grievance and appeal acknowledgements, extensions and decisions without prior written approval from the Department.

i. ***Section IV. E. Members, 6. Member Grievances and Appeals, b.*** **is revised to add the following:**

xiii. The PIHP shall apply the Member grievance, Internal Plan Appeals, and State Fair Hearing provisions outlined in this Section to any approved In Lieu of Service to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.

1. The offer or coverage of ILOS(s) shall in no way alter or diminish the Member's rights under 42 C.F.R. § 438 Subpart F.
2. Consistent with 42 C.F.R. § 438.402, a Member shall retain the right to file an appeal with regard to the denial or receipt of an ILOS.

j. ***Section IV. E. Members, 6. Member Grievances and Appeals, c. Member Grievance Process*** **is revised to add the following:**

viii. If a grievance relates to the denial of an expedited appeal request, the PIHP shall resolve the grievance and provide notice to the Member and, as applicable, the Member's Authorized Representative within five (5) Calendar Days from the date the PIHP receives the grievance. 42 C.F.R. § 438.408(b)(1).

k. ***Section IV. E. Members, 6. Member Grievances and Appeals, i. Appeals and Grievances Recordkeeping and Reporting, v. Appeals and Grievances Reporting, 2.*** **is revised and restated in its entirety as follows:**

2. To support the Department's monitoring efforts, the PIHP shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
   a. Each Notice of Adverse Benefit Determination issued by the PIHP;
   b. Each Notice of Resolution issued by the PIHP;
   c. Clearinghouse uploads should include English and the primary language of the member (if the Notice is sent in a language other than English); and
   d. Include required fields for Clearinghouse ingestion as set forth by the Notice of Adverse Benefit Determination Guide.

l. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, Section IV.F.1. First Revised and Restated Table 1: Behavioral Health, I/DD, and TBI Services Covered by PIHP*** **is revised and restated in its entirety as follows:**

Section IV.F.1. Second Revised and Restated Table1: Behavioral Health, I/DD, and TBI Services Covered by PIHP
• Inpatient BH Services
• Medically Managed Intensive Inpatient Services (Inpatient BH Services)
• Medically Managed Intensive Inpatient Withdrawal Services (Inpatient BH Services)
• Outpatient BH Emergency Room Services
• Outpatient BH Services Provided by Direct-Enrolled Providers
• Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments
• Peer Supports
• Partial Hospitalization

- Mobile Crisis Management
- Facility-Based Crisis Services for Children and Adolescents
- Professional Treatment Services in Facility-Based Crisis Program
- Outpatient Opioid Treatment
- Ambulatory Withdrawal Management, without Extended On-Site Monitoring (ambulatory detoxification)
- Ambulatory Withdrawal Management, with Extended On-Site Monitoring
- Clinically Managed Residential Withdrawal Services (social setting detoxification)
- Research-Based BH Treatment for Autism Spectrum Disorder (ASD)
- Diagnostic Assessment
- Medically Monitored Inpatient Withdrawal Management (non-hospital medical detoxification)
- Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization
- Residential Treatment Facility Services
- Child and Adolescent Day Treatment Services
- Intensive In-Home Services
- Multi-Systemic Therapy Services
- Psychiatric Residential Treatment Facilities (PRTFs)
- Assertive Community Treatment (ACT)
- Community Support Team (CST)[2]
- Psychosocial Rehabilitation
- Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house)[2]
- Clinically Managed Population-Specific High-Intensity Residential Services)[2]
- Clinically Managed Residential Services (Substance abuse non-medical community residential treatment)
- Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment)
- Substance Use Intensive Outpatient Program (SAIOP)
- Substance Use Comprehensive Outpatient Treatment Program (SACOT)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
- 1915(i) SPA Services:
  - Supported Employment/Individual Placement and Supports *
  - Individual Transition and Support
  - Respite
  - Community Living and Supports
  - Community Transition

m. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, c. Covered Medical Services, vi. Institutions for mental disease (IMD) SUD Services, 2.*** **is revised and restated in its entirety as follows:**

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

n. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, Section IV.F.1 Second Revised and Restated Table 6: Required Clinical Coverage Policies*** **is revised and restated in its entirety as follows:**

[2] Coverage to be applied on the effective date approved by CMS.

Section IV.F.1 Third Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	**Scope**
PIHP Services Note: *For these policies, PIHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.*	
Medicaid State Plan BH Services	8A: Enhanced Mental Health and Substance Abuse Services: • Child and Adolescent Day Treatment services • Intensive In-Home Services • Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization • Mobile Crisis Management • Multi-systemic Therapy Services • Partial Hospitalization • Professional Treatment Services in Facility-Based Crisis Program • Psychosocial Rehabilitation (PSR) • Substance Abuse Intensive Outpatient Program (SAIOP) • Substance Abuse Comprehensive Outpatient Treatment (SACOT) • Substance Abuse Non-Medical Community Residential Treatment (Clinically Managed High-Intensity Residential Services) • Substance Abuse Medically Monitored Residential Treatment (Medically Monitored Intensive Inpatient Services) 8A-1: Assertive Community Treatment 8A-2: Facility-Based Crisis Services for Children and Adolescents 8A-5: Diagnostic Assessment 8A-6: Community Support Team (CST) 8A-7: Ambulatory Withdrawal Management Without Extended On-Site Monitoring (ambulatory detox) [¥] 8A-8: Ambulatory Withdrawal Management With Extended On-Site Monitoring[¥] 8A-9: Opioid Treatment Program (OTP) 8A-10: Clinically Managed Residential Withdrawal Management Services (social setting detoxification)[¤] 8A-11: Medically Monitored Inpatient Withdrawal Management Services (non-hospital medical detoxification) [¥] 8B: Inpatient Behavioral Health Services 8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 8D-2: Residential Treatment Services 8F: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder 8G: Peer Supports 8I: Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population
Medicaid State Plan I/DD Services	8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
Medicaid State Plan 1915(i) Services	8H-1 Supported Employment for IDD and TBI 8H-2 Individual Placement and Support (IPS) 8H-3 Individual and Transitional Support (ITS) 8H-4 Respite 8H-5 Community Living and Support (CLS) 8H-6 Community Transition
Telehealth (for services within the scope of this Contract)	1-H: Telehealth, Virtual Communications and Remote Patient Monitoring
1915(c) Home and Community Based Services (HCBS) Waivers	8P: North Carolina Innovations

[¥] Clinical coverage policy was promulgated effective October 1, 2024.

[¤] Clinical coverage policy has not yet been promulgated. The Department will notify the PIHP consistent with contractual notice requirements of the effective date.

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

xix. To increase Member access to 1915(i), 1915(c), and 1915(b)(3) community living and supports (CLS), community networking, supported employment, and supported living, PIHPs shall achieve the following service utilization rates as demonstrated through the PIHP's submission of the 1915 Service Authorization Report:

1. By the fiscal year ending June 30, 2025, individuals authorized to receive CLS services through Innovations Waiver or 1915(i) will utilize no less than eighty-five percent (85%) of authorized CLS Service.

p. *Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services, ii., 2.* is revised and restated in its entirety as follows:

2. Prior to making any changes, reduction, or removal of ILOS, the PIHP shall submit the Department's standardized ILOS Service Termination Form to the Department for approval. If the request to change, reduce, or remove ILOS is approved, the PIHP shall notify all impacted Members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

q. *Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services, ii., 4*. is revised and restated as follows*:*

4. If a PIHP receives written notification from the Department that a previously approved ILOS has been determined by the Department or by CMS to no longer be medically appropriate or cost effective or if there are other compliance concerns with the ILOS requirements, including failures to protect Member rights, the PIHP shall submit a transition plan for the ILOS for current Members receiving the terminated ILOS to the Department for review and approval within the timeframe specified by the Department in the written notification. At a minimum, the transition plan shall include the following:
   a. A transition of care policy to phase out the applicable ILOS in no longer than twelve (12) months from receipt of the notice from the Department terminating the ILOS while ensuring access to services required under the Contract with minimal disruption to care for Members.
   b. A process to notify Members of the termination of the applicable ILOS for Members that are currently receiving the ILOS, as expeditiously as required by the Member's health condition.

r. *Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services, ii., 7*. is revised and restated in its entirety as follows*:*

7. The PIHP shall ensure that ILOS are provided in a manner that preserves Member rights and protections under State and federal law, including the following rights and protections related to ILOS:
   a. Members shall not be required by the PIHP to utilize an ILOS or be required to replace a Medicaid State Plan service with an ILOS. 42 C.F.R. §438.3(e)(2).
   b. The availability of an ILOS shall not be used by the PIHP to reduce, discourage, or jeopardize access by the Member to covered Medicaid State Plan services/settings.
   c. If a Member chooses not to receive an ILOS, the Member always retains the right to receive the covered Medicaid State Plan service or setting on the same terms as would apply if an ILOS was not available.
   d. Medically appropriate Medicaid State Plan services/settings shall not be denied by the PIHP on the basis that a Member was offered an ILOS, is receiving an ILOS, or has previously received an ILOS.
   e. The Member shall be able to access the PIHP's grievance and appeal system described in *Section IV.B.6. Member Grievances and Appeals* for any ILOS offered by the PIHP to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.

s. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services, ii.*** **is revised to add the following*:***

8. The PIHP is required to develop and implement a consistent process to ensure that network Providers requesting and/or the PIHP's licensed clinical staff recommending an ILOS for a Member uses professional judgment to determine and document (e.g., in the Member's care plan or medical record) that the ILOS is medically appropriate for the specific Member based on the ILOS target population descriptions outlined in *Section VI. First/Second Revised and Restated Attachment L. Policies, 7. Approved <Plan Name> In Lieu of Services.*

t. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, h.*** **is revised and restated in its entirety as follows:**

h. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements:
   i. Upon notification by the Department, the PIHP shall coordinate Specialized Services as defined in the federal PASRR regulations at 42 C.F.R. § 483.120 for Members admitted to nursing facilities and coordinate transition back to the community if or when the Member no longer meets medical necessity criteria for skilled nursing.
   ii. The PIHP shall arrange for the provision of Specialized Services identified by the PASRR process for Members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this Contract as listed in *Section IV.F.1. Behavioral Health and I/DD Benefits Package*.
      1. The PIHP shall confirm clinically appropriate State Specialized Services are documented in the nursing facility's plan of care for the Member and shall coordinate with the nursing facility and other providers, as relevant, to ensure linkage to PASRR Specialized Services.

u. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, b. Delivery of Tailored Care Management, ii. Provider-based Tailored Care Management, 3.*** **is revised and restated in its entirety as follows:**

3. The PIHP shall meet annual requirements set forth in *Section IV.G.2.b.ii.4* of this Contract for the percentage of Members actively engaged in Provider-based Tailored Care Management approaches, meaning Members assigned to Care Management Agencies (CMA) and Advanced Medical Home Plus (AMH+) providers.
   a. Reserved
   b. Reserved.
   c. Reserved.
   d. Reserved.
   e. Reserved.
   f. Reserved.
   g. Reserved.
   h. The percentage shall be calculated as:
      i. Numerator: Number of members assigned to AMH+ practices or CMAs certified by the Department for Tailored Care Management.
      ii. Denominator: Total number of Members assigned to a Tailored Care Management entity, including those assigned to AMH+, CMAs, and Plan-based care management.

v. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, e. Priority Populations for Engagement into Tailored Care Management, i., 4.*** **is revised and restated in its entirety as follows:**

4. Members in foster care, adoption assistance, and former foster youth.

w. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment and Re-Assignment, v.*** **is revised and restated in its entirety as follows:**

v. For all Members, the PIHP shall follow the requirements in the Tailored Care Management Auto Assignment Requirements Document, which will be published in the PCDU, as the PIHP develops the PIHP's Tailored Care Management auto assignment algorithm. The PIHP shall assign the Member to a contracted AMH+ practice, CMA, or PIHP within twenty-four (24) hours of effectuation date of enrollment with the PIHP. The Department will share specific deployment schedule for Tailored Care Management assignment that the PIHP will be required to follow. The algorithm must consider the Member's existing relationships with an AMH+ practice or CMA; the Member's medical, BH, and I/DD complexity; the Member's geographic location; and the capacity at an AMH+ practice or CMA. Criteria for a Provider-based Tailored Care Management Entity to meet Member care needs are described in this Contract and the latest version of the Tailored Care Management Auto Assignment Requirements Document. If a Member is receiving TCM services from a Provider-based Tailored Care Management Entity that is unable to meet the Member's care needs as specified in the Tailored Care Management Auto Assignment Requirements Document, the PIHP shall reassign the Member to an appropriate contracted Tailored Care Management Entity by the last day of the month in which the PIHP becomes aware that the Tailored Care Management Entity is unable to meet the Member's care needs per the Tailored Care Management Auto Assignment Requirements Document. In the event that the PIHP receives notification that a Provider cannot meet the Member's care needs within the last three (3) Calendar Days of the month and is unable to reassign the Member prior to the end of the month due to timing constraints, the Department expects the PIHP to reassign the Member by the last day of the next calendar month and to engage with the Member and address their care management needs until the Member is reassigned.

x. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment and Re-Assignment, viii.*** **is revised and restated in its entirety as follows:**

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

y. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment and Re-Assignment, x., 1.*** **is revised and restated in its entirety as follows:**

1. PIHP shall monitor care management assignment to ensure that AMH+ practices and CMAs do not select Members of their panel based on acuity tier. PIHP must default Members in foster care, adoption assistance, and former foster youth to PIHP-based Tailored Care Management, with the exception of Members who transition from a BH I/DD Tailored Plan or were previously assigned to an AMH+ or CMA who must be auto-assigned to the same AMH+/CMA. However, Members in foster care, adoption assistance, and former foster youth must also be given the option to select an AMH+ or CMA.

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

i. For Members in foster care, the PIHP shall ensure that the assigned organization providing Tailored Care Management arranges an initial meeting with the Member's assigned County Child Welfare Worker (in-person, by video, or telephonic).

aa. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, h. Coordination with County Child Welfare Workers for Members involved in the Child Welfare System Engaged in Tailored Care Management*** **is revised to add the following:**

vi. For Members in adoption assistance, the PIHP shall ensure that the assigned organization providing Tailored Care Management arranges an initial meeting with the Member's parent or legal guardian. These meetings may be in-person, by video, or telephonic depending on the Member's parent or legal guardian's preference.

vii. For Members in former foster care, the PIHP shall ensure that the assigned organization providing Tailored Care Management arranges an initial meeting with the Member, Authorized Representative, or legal guardian. These meetings may be in-person, by video, or telephonic based on the preference of the Member, Authorized Representative, or legal guardian.

bb. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management, xv. 24.*** **is revised and restated in its entirety as follows:**

24. For Members in foster care, permanency planning goals.

cc. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, xi.*** **is revised and restated in its entirety as follows:**

xi. The PIHP shall not require an AMH+ practice, CMA, or CIN or Other Partner to undergo a pre-delegation audit for the purposes of NCQA accreditation in the first year of this Contract. The PIHP must ensure that in conducting oversight of AMH+ practices and CMAs it is monitoring Tailored Care Management-specific requirements contained in this Contract and the Tailored Care Management Provider Manual available at the following link, accurate as of the date of execution of this Contract: https://medicaid.ncdhhs.gov/tailored-care-management.

dd. ***Section IV. G. Care Management and Care Coordination, 3. Care Coordination and Care Transitions for All Members*** **is revised to add the following:**

j. To assist with the identification of the prevalence of and service delivery needs for Members living with brain injury, the PIHP shall conduct brain injury screening to identify Members who have likely sustained a brain injury in their lifetime. Screening shall be conducted at either the PIHP call center or at a contracted provider assessment agency, as determined by mutual agreement between the parties. Results shall be reported on a quarterly basis using the standardized traumatic brain injury (TBI) report template provided by the Department as defined in *Section VI. Fifth Revised and Restated Attachment I. Reporting Requirements*.

ee. ***Section IV. G. Care Management and Care Coordination*** **is revised to add the following:**

14. Competitive Integrated Employment for Individuals with I/DD
    a. The PIHP shall participate in the Department's ongoing efforts to improve and enhance opportunities for individuals with I/DD to engage in competitive integrated employment. The PIHP shall:
        i. Coordinate and oversee employment services and supports for Members with I/DD who are interested in pursuing competitive integrated employment who are receiving ADVP Services or the Day Components of ICF-IID In Lieu of Services which are provided in a setting licensed as an ADVP as described in *Section IV. Scope of Services, G. Care Management and Care Coordination, 5. Care Coordination Responsibilities for Members with an Unmet BH, I/DD, or TBI-Related Need Who Are Not Engaged in Tailored Care Management, a., xiii.*
        ii. Conduct coordination of employment services with the goal of facilitating the Member in exploring, obtaining and maintaining employment in a competitive and integrated setting.
        iii. Work cooperatively with the Department, community providers, and Members and their families to implement the Department's CIE I/DD Strategic Plan. The CIE IDD Strategic Plan will be developed with input from key stakeholders including the PIHP, community providers, and Members and their families.
        iv. Complete the CIE Data Collection Tool provided by the Department, as described in *Section VII. Fifth Revised and Restated Attachment I. Table 1,* and submit it to the Department within thirty (30) Calendar Days after the last day of each calendar quarter, and work cooperatively with the Department to explain or clarify any data submitted in the CIE Data Collection Tool upon the Department's request.
        v. Participate in the MCO CIE Stakeholder Advisory Group for CIE in accordance with the schedule established by the Department.
        vi. Participate in other ad hoc activities that promote inclusive employment, which may include without limitation, one-on-one meetings between the Department and the PIHP, targeted quality improvement activities, or other activities as determined by the Department, upon request and reasonable prior notice by the Department.

ff. ***Section IV. H. Providers, 2. Provider Network Management, e. Critical Incident Reporting*** **is revised and restated in its entirety as follows:**

e. Critical Incident Reporting
    i. The PIHP shall develop and submit to the Department a written policy or process for timely identification, response, reporting, and follow-up to Member incidents and for reviewing, investigating, and analyzing trends in critical incidents and deaths as defined in 10A NCAC 27G .0602. The policy or process shall be submitted by the PIHP to the Department by June 30th, 2025, and annually by June 30th of each calendar year thereafter. The policy or process shall include preventive action efforts to minimize the occurrence of Member critical incidents and/or death.
    ii. The PIHP shall require Category A and B Providers, as those terms are defined in 10A NCAC 27G .0602(8), to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602(4) and (5), in the NC Incident Response Improvement System.
    iii. The PIHP shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and 10A NCAC 27G .0605 to ensure the health and safety of the PIHP Members.
    iv. The PIHP shall report on a quarterly cadence aggregate information on critical incidents and deaths in accordance with Department procedures as defined in 10A NCAC 27G .0609 to the PIHP Board, the Human Rights committee and the CFAC quarterly.
    v. Reserved.

vi. The PIHP shall ensure that Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VI. Third Revised and Restated Attachment F. Required Standard Provisions for PIHP and Provider Contracts.* If a Provider is not complying or there are trends in incident reporting, the PIHP will utilize processes including but not limited to provider monitoring and corrective actions to minimize occurrence of preventable incidents and to ensure health and safety of Members receiving services.

vii. The PIHP shall adhere to the critical event reporting requirements for Members obtaining services in a DSOHF facilities as detailed in *Section VI. First Revised and Restated Attachment M. Addendum for Division of State Operated Healthcare Facilities Providers.*

gg. *Section IV. H. Providers, 2. Provider Network Management, h. Credentialing and Re-credentialing Process, ix.* is revised and restated in its entirety as follows:

ix. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to *Section III.B.5. Availability of Funds*, DHHS shall indemnify, defend, and hold harmless the PIHP, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the PIHP by the Department, Contract Verification Organization, or other Vendor providing such information to the PIHP and relied upon by the PIHP in credentialing a Provider for participation in the PIHP's Network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The PIHP shall have the option to participate at its own expense in the defense of such claims or actions filed and the PIHP shall be responsible for its own litigation expenses if it exercises this option. In no event shall the PIHP be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The PIHP shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the PIHP's use of and reliance on such credentialing information.

hh. *Section IV. H. Providers, 2. Provider Network Management, i. Network Provider System Requirements, ii.* is revised and restated in its entirety as follows:

ii. Unless otherwise written in the Contract, the PIHP shall load contracted Providers into the claim adjudication and payment system within the following time frames to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the PIHP by the Provider:

1. NC Medicaid Provider attached to a new contract within ten (10) Business Days after completing contract execution.
2. NC Medicaid hospital or facility attached to a new contract within fifteen (15) Business Days after completing contract execution.
3. Reserved.
4. Reserved.
5. Change in existing contract terms within fifteen (15) Business Days of the effective date after the change.
6. Reserved.

ii. ***Section IV. H. Providers, 2. Provider Network Management, i. Network Provider System Requirements, viii. Provider Directory, 4.*** **is revised and restated in its entirety as follows:**

4. In accordance with 42 C.F.R. § 438.10(h)(3)
    i. The PIHP shall update the paper directory quarterly if the PIHP has an electronic, mobile-enabled provider directory, or monthly if they do not.
    ii. The PIHP shall update the electronic version of the Network Directory no later than thirty (30) Calendar Days after the PIHP receives updated provider information from the Department and clearly identifies the date of the update.

jj. ***Section IV. H. Providers, 2. Provider Network Management, i. Network Provider System Requirements, viii. Provider Directory, 7.*** **is revised and restated in its entirety as follows:**

7. The Member facing Provider directory must comply with 42 C.F.R. § 438.10(h)(1)(i) –(viii) and 42 C.F.R. § 438.10(h)(2)~~.~~ and shall include the following information, at a minimum:
    i. Provider name;
    ii. Provider demographics (first, middle, and last name, gender);
    iii. Provider DBA Name;
    iv. Reserved;
    v. Provider type (including if the provider is also an AMH+ or CMA);
    vi. Reserved;
    vii. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
    viii. Street address(as) of service location(s);
    ix. County(ies) of service location(s);
    x. Telephone number(s) at each location;
    xi. After hours telephone number(s) at each location;
    xii. Provider specialty by location;
    xiii. Whether provider is accepting new Medicaid-covered patients;
    xiv. Whether provider serves Medicaid beneficiaries;
    xv. Whether a BH provider is serving children and adolescents;
    xvi. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
    xvii. Whether provider has completed Cultural and Linguistic Competency training;
    xviii. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment; and
    xix. A telephone number at the PIHP where a member can call to confirm the information in the directory.
8. In no case shall a provider be loaded into the provider directory which cannot receive payment on the PIHP's current payment cycle. This provision does not apply to Providers suspended by the Department.
9. The PIHP shall provide the provider directory to the Department's designated vendor for inclusion in the Consolidated Provider Directory made available to the Enrollment Broker as described in *Section IV.L. Technical Specifications*.
10. As long as the PIHP Provider Directory clearly identifies which providers are available under which health plan, a unified Provider Directory may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan Contract.

kk. ***Section IV. H. Providers, 4. Provider Payments, m. Payment under Locum Tenes Arrangements, i.*** **is revised and restated in its entirety as follows:**

i. The PIHP shall recognize locum tenens arrangements to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 42 C.F.R. § 455.410(b).

ll. ***Section IV. H. Providers, 4. Provider Payments, t. Electronic Visit Verification (EVV) Payments, i.*** **is revised and restated in its entirety as follows:**

i. The PIHP shall maintain increased reimbursement from February 1, 2023 to providers subject to EVV requirements by an amount that is no less than ten (10) percent of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic. This uniform percentage increase shall be in addition to required rate increases related to Direct Care Worker wage initiatives defined below. If a provider chooses to require or offer Direct Care Workers who are permitted to be exempt or not subject to federal EVV requirements to comply with EVV requirements, the PIHP shall not be required to pay the EVV reimbursement rate increase for such claims, and/or shall be permitted to require the Provider to not submit these claims through the EVV system.

mm. ***Section IV. H. Providers, 4. Provider Payments, cc. Hospital Payments for Behavioral Health Claims, i.*** **is revised and restated in its entirety as follows:**

i. For dates of service on or after January 1, 2024, the PIHP 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 by CMS ($895.63), unless the PIHP and Provider have mutually agreed to an alternative reimbursement arrangement established on or after January 1, 2024. For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section IV.J.1.d.iv*).

nn. ***Section IV. H. Providers, 4. Provider Payments*** **is revised to add the following:**

dd. PIHPs shall be responsible for directly paying the vendor for the following Innovations Waiver services after UM approval is received regardless of what TCM entity (Plan, AMH+, CMA) they are assigned to:
   i. Assistive Technology Equipment and Supplies
   ii. Community Networking
      1. Class and conference payment for attendance fees at classes and conferences is also included;
      2. Payment for memberships shall be covered when the Member participates in an integrated class; and
      3. Transportation, when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage set by the PIHP;
   iii. Home Modifications;
   iv. Individual Goods and Services;
   v. Natural Supports Education;
   vi. Vehicle Adaptation; and
   vii. Meal Delivery Service.

ee. Payment for Substance Use Disorder (SUD) Services
   i. For dates of service on or after October 1, 2024, the PIHP shall reimburse in-network providers of substance use disorder (SUD) services at no less than one hundred percent (100%) of the Enhanced Mental Health Medicaid Fee-for-Service Fee Schedule rate, as set by the Department, unless the PIHP and Provider have mutually agreed to an alternative reimbursement arrangement established on or after October 1, 2024. For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest consistent with the requirements of *Section IV.J.1.d.iv.*

oo. ***Section IV. H. Providers, 5. Provider Grievances and Appeals, a.-b.*** **is revised and restated in its entirety as follows:**

a. The PIHP shall handle Provider Appeals and Grievances promptly, consistently, fairly, and in compliance with State and federal law and Department requirements. The PIHP shall have in place a Provider Appeals and Grievance system, distinct from that offered to Members, that includes a Grievance process for Providers to bring issues to the PIHP, an Appeals process for Providers to challenge certain PIHP decisions, and information regarding recourse available under contract or law. The PIHP shall be transparent with Providers regarding its Appeals and Grievance processes and procedures. The PIHP shall ensure the Grievance and Appeals system comply with *Section III.B.42.* ***SUBCONTRACTORS***, if PIHP has contracted with a Subcontractor for the Grievance and Appeals system.

b. Reserved.

pp. ***Section IV. I. Quality and Value, 1. Quality Management and Quality Improvement, m. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330), v. – vi*****. is revised and restated in its entirety as follows:**

v. The PIHP shall conduct at least one (1) non-clinical performance improvement project on an annual basis that is related to diversion, in-reach and/or transition for populations in or at risk of entrance into institutional or ACH settings.

vi. The PIHP shall conduct two (2) clinical performance improvement projects annually that align with aims, goals, objectives, and interventions outlined within the Department's Quality Strategy and must be related to one or more of the following areas:

1. Maternal health;
2. Tobacco cessation;
3. Diabetes prevention;
4. Birth outcomes;
5. Early childhood health and development;
6. Hypertension; and
7. Behavioral-physical health integration.

qq. ***Section IV. I. Quality and Value, 2. Value-Based Payments (VBP), e., ii.-iv.*** **is revised and restated in its entirety as follows:**

ii. No later than September 30, 2025, the PIHP shall submit for the Department review and approval Contractor's VBP Assessment conducted on VBP contracts entered or effective during the previous contract year. The VBP Assessment may be conducted as a single assessment shared across and inclusive of activities arising under this product and the PIHP's BH I/DD Tailored Plan contract with the Department.

iii. Reserved.

iv. No later than ninety (90) Calendar Days following the end date of each subsequent Contract Year, the PIHP shall submit for Department review and approval Contractor's updated VBP Assessment on all VBP contracts entered or effective during the Contract Year. The VBP Assessment may be conducted as a single assessment shared across and inclusive of activities arising under this Contract and the PIHP's BH I/DD Tailored Plan contract with the Department.

rr. ***Section IV. I. Quality and Value, 2. Value-Based Payments (VBP), f.*** **is revised and restated in its entirety as follows:**

f. To ensure the PIHP's VBP Arrangements align with the Department's strategy and goals, the PIHP shall develop a VBP Strategy in alignment with the Department's short- and long-term goals to shift from a Fee-for-Service system to VBP model.

i. The VBP Strategy must be submitted to the Department upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
ii. As long as the VBP Strategy clearly states that it applies to the PIHP, the PIHP may develop a single VBP Strategy shared across and inclusive of other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.
iii. No later than ninety (90) Calendar Days following the end date of each Contract Year, the PIHP shall submit to the Department for review and approval Contractor's update on all sections of the VBP Strategy outlined in I of this Contract. The VBP Strategy updates may be conducted across and inclusive of activities arising under this product and the BH I/DD Tailored Plan.
iv. The VBP Strategy shall contain the following elements:
    1. A narrative description addressing:
        i. The PIHP's goals, strategies, and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the PIHP will involve BH and intellectual and developmental disability providers in its VBP arrangements.
        ii. A description of the VBP model(s) that will be pursued by the PIHP and its providers and their HCP-LAN classification, including a description of the required performance incentive programs for AMH+ practices and CMAs, which must be consistent with requirements for Tailored Care Management payment, and a description of VBP arrangements offered to non-AMH+/CMA providers. The PIHP's plan for measurement of outcomes and results related to VBP by year.
        iii. The PIHP's approach to address Unmet Health-Related Resource Needs as part of its VBP strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes.
        iv. A description of the PIHP's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the PIHP VBP programs. Specific functionalities to address include:
            a. Risk adjustment;
            b. Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
            c. Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;
            d. Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
            e. Reporting capabilities; and
            f. Payment functions.
        v. The PIHP's approach to address health disparities and incorporate health equity into their internal and external policies, and procedures.
    2. The PIHP's projected annual targets for VBP contracts with providers in HCP-LAN Levels 1 through 4, in a format to be determined by the Department.

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

xi. No later than April 1, 2025, the PIHP shall process crossover claims received from providers and NC Medicaid Systems including NCTracks for Members enrolled in the Innovations Waiver or TBI Waiver program.

tt. ***Section IV. J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, i.*** **is revised to add the following:**

3. For purposes of claims payment, the PIHP shall be deemed to have paid the claim as of the Date of Payment, and the PIHP shall be deemed to have denied the claim as of the date the remittance advice is sent.

uu. ***Section IV. J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. Claim Submission Timeframes, 1., i.*** **is revised to add the following:**

b. When a claim requires financial eligibility determination, the PIHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date the patient monthly liability (PML) is determined.

vv. ***Section IV. J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. Claim Submission Timeframes, 2., i.*** **is revised to add the following:**

b. When a claim requires financial eligibility determination, the PIHP may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date the patient monthly liability (PML) is determined.

ww. ***Section IV. J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties*** **is revised and restated in its entirety as follows:**

1. The PIHP shall pay interest to the Provider, including, but not limited to, AMH+ practices and CMAs, on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract.
2. Reserved.
3. The PIHP shall not be subject to interest or penalty payments if failure to comply is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the PIHP's reasonable control, including Force Majeure. In addition, the PIHP is not subject to interest payments to the Provider if the PIHP has a reasonable basis to believe that the Claim was submitted fraudulently.
4. The PIHP shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's Fee Schedule and Covered Code website or PCDU.
    i. The PIHP shall reprocess all impacted claims with dates of services from the effective date of the NC Medicaid fee schedule change with correct rates, including sending notification of overpayments to impacted Providers, within an additional thirty (30) Calendar Days of implementing fee schedule changes.
    ii. This standard is only applicable for NC Medicaid rate floor programs.
    iii. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section.
5. All references to penalty(ies) paid to a Provider as a result of late payments to Providers are hereby stricken as of July 1, 2024.

xx. ***Section IV. J. Claims and Encounter Management, 1. Claims, e. Overpayment or Underpayment Recovery, ii.*** **is revised and restated in its entirety as follows:**

ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), the PIHP may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments to the Provider. Any such recoveries may also include related interest payments that were made under the requirements of this Section. Not less than sixty (60) Calendar Days before the PIHP

seeks overpayment recovery or offsets future payments to the Provider, the PIHP shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two (2) years after the date of the original claim payment unless the PIHP has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents. The health care provider or health care facility may recover underpayments or non-payments by the PIHP by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the PIHP may include applicable interest under this section. The recovery of underpayments or non-payments shall be made within the two (2) years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

yy. ***Section IV. J. Claims and Encounter Management, 1. Claims, h. National Correct Coding Initiative, ii.*** **is revised and restated in its entirety as follows:**

ii. The PIHP shall follow NC Medicaid NCCI policies to control improper coding that may lead to inappropriate payments to providers by the PIHP.

zz. ***Section IV. J. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, i., 1. Timeliness*** **is revised to add the following:**

iv. Medical: for purposes of determining if the PIHP has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH and AMH+ monthly medical home fees, and CMHRP and Healthy Opportunities per member per month payments.

aaa. ***Section IV. J. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, i., 2. Accuracy*** **is revised to add the following:**

ii. Medical: for purposes of determining if the PIHP has met the accuracy encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH and AMH+ monthly medical home fees, and CMHRP and Healthy Opportunities per member per month payments.

bbb. ***Section IV. K. Financial Requirements, 2. Medical Loss Ratio, b.*** **is revised and restated in its entirety as follows:**

b. PIHP shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two (2) bases as follows:
   i. PIHP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).
      1. For the April 1, 2023 through June 30, 2024 rating period, PIHP shall report the CMS-defined MLR separately for April 1, 2023 through June 30, 2023 and July 1, 2023 through June 30, 2024 time periods to align with the MLR reporting year as defined in 42 C.F.R. § 438.8(b). For each subsequent rating period, the PIHP shall report the CMS-defined MLR aligned to the MLR reporting year as defined in 42 C.F.R. § 438.8(b).
      2. The CMS-defined MLR shall be reported in aggregate combined for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

3. The numerator of PIHP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of PIHP's incurred claims, expenditures for activities that improve health care quality and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
4. The denominator of PIHP's CMS-defined MLR for a MLR reporting year shall equal PIHP's adjusted premium revenue. The adjusted premium revenue shall be defined as PIHP's premium revenue minus PIHP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).

ii. PIHP shall calculate Department-defined MLR experienced for all Non-Expansion populations in a MLR reporting year as the ratio of the numerator and denominator.
1. PIHP shall report the Department-defined MLR for the entire April 1, 2023 through June 30, 2024 rating period. For each subsequent rating period, the PIHP shall report the Department-defined MLR aligned to the MLR reporting year set forth in 42 C.F.R. § 438.8(b).

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

ccc. *Section IV. K. Financial Requirements, 2. Medical Loss Ratio, c.ii.* is revised and restated in its entirety as follows:

ii. PIHP shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:
1. Interest or penalty payments to providers for failure to meet prompt payment standards;
2. Fines and liquidated damages assessed by Department or other regulatory authorities;
3. Rebates paid to Department if PIHP's Department-defined MLR is less than the minimum MLR threshold for a prior year;
4. Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of rebates paid to Department if PIHP's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in *Sections IV.K.2.d*. and *IV.K.2.i.iii.*;
5. PIHP shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations; and
6. Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of remittance paid to the Department if the PIHP's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Sections IV.K.4.k.ix.*, *IV.K.4.l.vi.10.*, *IV.K.4.m.xi.9.*, and *IV.K.4.n.vi.10.* of this Contract.

ddd. ***Section IV., K. Financial Requirements, 2. Medical Loss Ratio, c.iii.*** **is revised and restated in its entirety as follows:**

iii. PIHP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating the CMS-defined MLR and all Non-Expansion Medicaid eligibility groups for the Department-defined MLR.

eee. ***Section IV. K. Financial Requirements, 2. Medical Loss Ratio, i. Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population, i.*** **is revised and restated as follows with no changes to subparts 1.-7.:**

i. PIHP shall calculate and report a distinct aggregate Department-defined MLR for Medicaid Expansion Eligible Member population on an annual basis aligned to the rating period (from the start of Medicaid Expansion through June 30, 2024) and annually thereafter.

fff. ***Section IV. K. Financial Requirements, 2. Medical Loss Ratio, i.*** **is revised to add the following:**

ix. In any instance where the Department makes a retroactive change to the capitation rates for a MLR reporting year where the MLR report has already been submitted to the Department, the PIHP shall:
1. Re-calculate the MLR for all MLR reporting years affected by the change, and
2. Submit a new MLR report meeting the applicable requirements in 42 C.F.R. § 438.8(k) in accordance with 42 C.F.R. § 438.8(m).

ggg. ***Section IV. K. Financial Requirements, 4. Risk Corridor*** **is revised to add the following:**

m. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations for State Fiscal Year 2025
i. A risk corridor arrangement between PIHP and Department will apply to share in gains and losses of PIHP Non-Medicaid Expansion Eligible Member populations as defined in this section. The Risk Corridor payments to and recoupments from PIHP will be based on a comparison of PIHP's reported Risk Corridor Services Ratio ("Reported Services Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in Medicaid PIHP Rate Book ("Target Services Ratio").
ii. The Risk Corridor Measurement Period is defined as July 1, 2024 to June 30, 2025.
iii. The risk corridor payments and recoupments will be based on a comparison of PIHP's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by Department. The Target Services Ratio will be documented in the Medicaid Direct BH PIHP Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.
iv. PIHP Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the Medicaid Direct BH PIHP Rate Book and weighted by PIHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments and Tailored Care Management payments outside of monthly capitation).
v. The Reported Services Ratio numerator shall be PIHP's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care program. The numerator shall be defined as the sum of:
1. Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments.
2. Other quality-related incentive payments to NC Medicaid providers.
3. Non-claims based provider stabilization payments to support provider sustainability and beneficiary access.

4. Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.

vi. PIHP is prohibited from including in the Reported Services Ratio numerator the following expenditures:
   1. Payments to providers and PIHP expenses for Tailored Care Management.
   2. Payments to providers for delegated Care Management.
   3. Interest or penalty payments to providers for failure to meet prompt payment standards.
   4. Payments to related providers that violate the Payment Limitations as required in the Contract.
   5. Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation.
   6. Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of rebates paid to the Department if the PIHP's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in *Sections IV.K.2.d.* and *IV.K.2.i.iii.* of this Contract.
   7. Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of remittance paid to the Department if the PIHP's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Sections IV.K.4.k.ix.*, *IV.K.4.l.vi.10.*, *IV.K.4.m.xi.9.*, and *IV.K.4.n.vi.10.* of this Contract.

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

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

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

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

xi. Risk Corridor Settlement and Payments
   1. Department will complete a settlement determination for the Risk Corridor Measurement Period.
   2. PIHP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by Department.
   3. PIHP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
   4. PIHP shall provide additional information and documentation at the request of Department to support the Risk Corridor Settlement determination.
   5. Department may choose to review or audit any information submitted by PIHP.

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

n. Risk Corridor for Medicaid Expansion Eligible Member Population State Fiscal Year 2025
    i. A distinct risk corridor arrangement between PIHP and Department will apply to share in gains and losses of PIHP for Medicaid Expansion Eligible Member populations as defined in this Section. The Risk Corridor payments to and recoupments from PIHP will be based on a comparison of PIHP's reported Risk Corridor Services Ratio ("Reported Services Ratio") for the Risk Corridor Measurement Period as defined in this Section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Medicaid Direct BH PIHP Rate Book ("Target Services Ratio").
    ii. The risk corridor parameters for Medicaid Expansion Eligible Member population shall be consistent with those defined for the non-Medicaid Expansion population in *Section IV.K.4.m.iii.-ix.* of the Contract. Determination of payments and recoupments for Medicaid Expansion Eligible Member populations shall be calculated separately from the non-Medicaid Expansion population.
        1. The Risk Corridor Measurement Period is defined as July 1, 2024 to June 30, 2025.
        2. The numerator and denominator calculations for the Target Services Ratio and Reported Services Ratio, including exclusions, will be consistent with those defined in *Section IV.K.4.m.iv.-vi.* of the Contract.
        3. The risk corridor payments and recoupments will be based on a comparison of PIHP's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by Department. The Target Services Ratio will be documented in the

Medicaid Direct BH PIHP Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.

4. The PIHP Target Services Ratio for Medicaid Expansion Eligible Member populations shall be calculated using the Target Services Ratio for each applicable rate cell documented in the Medicaid Direct BH PIHP Rate Book and weighted by PIHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments and Tailored Care Management payments outside of monthly capitation).

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

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

v. Terms of the Risk Corridor

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

vi. Risk Corridor Settlement and Payments

1. Department will complete a settlement determination for the Risk Corridor Measurement Period. This determination shall be made for the Medicaid Expansion Eligible Member population independent of the non-Medicaid Expansion population determination.
2. PIHP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by Department.
3. PIHP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
4. PIHP shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.
5. PIHP shall provide additional information and documentation at the request of Department to support the Risk Corridor Settlement determination.
6. Department may choose to review or audit any information submitted by PIHP.
7. Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, Department will make final decisions about covered costs included in the settlement.
8. Department will provide PIHP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to *Section V. Contract Performance* within thirty (30) Calendar Days of the notice by Department to PIHP.
9. If the final Risk Corridor Settlement requires PIHP to remit funds to Department, the PIHP must submit any undisputed remittance to Department within ninety (90) Calendar Days of the date of Department's notification of the final Risk Corridor settlement. If PIHP initiates a dispute as described in *Section V. Contract Performance* the deadline for PIHP to submit remittance to Department shall be stayed pending the outcome of the dispute.
10. At the sole discretion of Department, Department may allow PIHP to contribute all or a part of the amount otherwise to be remitted to:

a. Contributions to health-related resources targeted towards high-impact initiatives that align with Department's Quality Strategy that have been reviewed and approved by the Department.
b. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by Department.

11. To be considered for the in lieu of remittance option as described in *Section IV.K.4.m.vi.10.*, PIHP must submit a proposal to Department for review and approval concurrent with or prior to submission of PIHP's interim Risk Corridor Services Ratio report.
12. If PIHP has not made a required remittance payment within the final date required by this Section, Department may choose to recover any obligation due from PIHP by offsetting a subsequent monthly capitation payment. For avoidance of doubt, a disputed remittance payment will not be considered required until such dispute is resolved in accordance with *Section V. Contract Performance*.
13. If the final Risk Corridor Settlement requires Department to make additional payment to PIHP, Department shall submit payment within ninety (90) Calendar Days after Department's notification of the final Risk Corridor settlement. If PIHP initiates a dispute as described in *Section V. Contract Performance* the deadline for Department to make the additional required payments shall be stayed pending the outcome of the dispute.
14. The Medicaid Expansion Eligible Member population risk corridor shall be settled in advance of the final minimum Medicaid Expansion MLR reporting and determination.

hhh. *Section IV. L. Technical Specifications, 5. Provider Directory, a.* is revised and restated in its entirety as follows:

a. The Department's designated vendor shall validate and integrate the Provider directory information transmitted by the PIHP and supply the Enrollment Broker and NC Fast with a Consolidated Provider Directory to support PIHP choice counseling and selection.
   i. The PIHP should use the National Provider Identifier (NPI) enrolled with the Department and the Department's specified key as the unique provider identifier for the location. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by the Department's should be used.
   ii. The PIHP shall ensure the Provider Directory aligns with the parameters laid out in *Section III.B.42. Subcontractors*, if the PIHP delegates this activity to a Subcontractor.
   iii. The PIHPs shall verify that all Providers included in the Provider Directory are actively enrolled in NC Medicaid.

iii. *Section IV. L. Technical Specifications, 6. Technology Documents, b.* is revised and restated in its entirety as follows:

b. Security Documentation: The PIHP must comply with all federal, State and NC DHHS Privacy and Security policies as outlined in the State and DHHS Security manuals. These manuals are available at the following link, accurate as of December 9, 2024: https://it.nc.gov/documents/statewide-information-security-manual. In compliance with this policy, the NC DHHS Privacy and Security Office and the Department of Information Technology require at a minimum the following three (3) documents to be submitted by the PIHP as set forth below. As long as the System Security Plan, Vendor Readiness Assessment Reports, and SOC 2 Type II Reports or Self-assessments clearly state that they apply to the PIHP, they may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.
   i. Vendor Readiness Assessment Report (VRAR) - The VRAR and its underlying assessment are intended to enable DHHS to reach a state-ready decision for a specific vendor solution, hosted on or off the State network based on organizational processes and the security capabilities of the

information system. The VRAR must be submitted annually no later than March 31st of each Contract year. The PIHP shall complete the VRAR using the template accessed here: https://it.nc.gov/documents/files/vendor-readiness-assessment-report-non-state-hosted-solutions/open .

ii. System Security Plan (SSP): The PIHP shall provide a plan that details how the PIHP will comply with the Department Confidentiality, Privacy and Security Protections requirements as outlined in the Contract or in the State or NC DHHS security manuals referenced above using the template provided by the Department. The SSP shall be updated and submitted annually no later than March 31st of each Contract year to the Department for review. If access to the template for the SSP is required, please request from the Department.

iii. SOC 2 Type II Report

1. The PIHP must submit a completed Soc 2 Type II report annually no later than March 31st of each Contract Year. If the technology platform used to deliver the services under this Contract has not been used in a production setting prior to the go live of the PIHP, a Self-Assessment and externally conducted penetration test must be performed on the technology platform and submitted to the Department prior to go live, in lieu of the Soc 2 Type II.
    i. The PIHP may only submit a Self-Assessment and External Penetration Test in lieu of the SOC 2 Type II at or prior to go-live, unless prior approval has been obtained from the Department.
    ii. Reserved.
    iii. The PIHP shall submit to the Department no later than March 31st of each Contract Year its SOC 2 Type II report and bridge letter covering the duration of the entire Contract Year.
    iv. The PIHP shall collect and review the final SOC 2 Type II reports or other acceptable audit or assessments from all of its Subcontractors to confirm Subcontractor compliance with the privacy and security requirements in this Contract and relevant Department, State, and federal security rules, regulations, policies, and statutes in accordance with *Sections III.B.42.* and *III.C.* of this Contract. Upon Department Request, the PIHP shall provide to the Department a copy of the final SOC 2 Type II report(s) and/or other acceptable audit or assessment for the PIHP's Subcontractor(s).

jjj. ***Section IV. M. Innovation Waiver Services, 3. Tailored Care Management, a. Eligibility for Tailored Care Management, v.*** **is revised to add the following:**

4. PIHPs shall ensure that all Innovations Waiver certified care managers are properly trained to support Members new to the Innovations Waiver to successfully access appropriate Home and Community Based Services.
5. PIHPs shall provide or monitor equivalent training that AMH+ or CMA entities certified to serve Innovations Waiver Members must receive, including but not limited to training related to services and activities set forth in Clinical Coverage Policy 8P, as needed to adequately meet the Innovations Waiver Member needs. Plan and provider-based Tailored care managers must all meet these training requirements.

kkk. ***Section IV.*** **is revised to add the following:**

O. Clinically Appropriate Placement of Minors

1. Within one (1) Business Day, or as soon as reasonably feasible thereafter, of the PIHP's receipt of written notification that a Member under eighteen (18) years of age remains in the Emergency Department ready for discharge and in need of Medicaid State Plan enhanced behavioral health services that include, if medically necessary, residential treatment and/or PRTF service upon discharge from the Emergency Department, the PIHP shall demonstrate best efforts to arrange for

the Member to receive such services in an appropriate placement with the approval of the Member's guardian or legally responsible person (LRP). The PIHP shall report to the Department weekly on all such Members through the BCM-073-M Report. To the extent that the Department requires additional information on any individual Member listed on the BCM-073-M Report, the Department shall notify the PIHP through the PCDU.

a. A Member's need for such services shall be determined through a Comprehensive Clinical Assessment (CCA) or similar evaluation. To the extent that the Emergency Department, guardian, LRP, contracted provider, or external TCM provider or other person/entity does not permit the PIHP and its contracted providers to have prompt and timely access to the Member to conduct and complete a full, timely and valid CCA or similar evaluation, the PIHP shall notify the Department's Rapid Response Team (RRT), which will collaborate with the PIHP and other persons and entities to ensure a CCA or similar evaluation is timely completed.

2. For any Member under eighteen (18) years of age who is taken into physical DSS custody and requires Medicaid State Plan enhanced behavioral health services that include residential treatment and/or PRTF services the PIHP shall demonstrate best efforts to arrange for the Member to be appropriately placed within twenty-four (24) hours, or as soon as reasonably feasible thereafter, of the PIHP's receipt of notification from DSS that the Member is in DSS physical custody and the PIHP determines requires such services are medically necessary. The PIHP shall demonstrate best efforts to avoid such a Member ~~is not~~ being boarded overnight in a DSS office, hotel, or similar placement. Automatic referral to a hospital emergency department for services does not satisfy this requirement. The PIHP shall report to the Department weekly on all such Members through the BCM-073-M Report. To the extent the Department requires additional information on any individual Member listed on the BCM-073-M Report, the Department shall notify the PIHP through the PCDU.

   a. Nothing in this Section requires the PIHP to arrange for placement outside the recommended level of care in the Member's CCA, or where there is no availability of placement in the PIHP network, including facilities operated by DSOHF. In the event that the parent, legal guardian or legal custodian of a Member under eighteen (18) years of age identified in this section rejects or refuses admission to appropriate placement identified by the PIHP, the PIHP shall make best efforts to identify a mutually agreeable placement within the recommended level of care, but shall, in no case later than twenty-four (24) hours of receiving the parent, legal guardian or legal custodian's rejection of appropriate placement identified by the PIHP, demonstrate best efforts to arrange for placement of the Member in an appropriate setting for receipt of medically necessary Medicaid State Plan enhanced behavioral health services to include residential placement in a licensed facility, subject to the parent's, legal guardian's, or legal custodian's consent.

IV. Modifications to Section V. Contract Performance

Specific subsections are modified as stated herein.

a. *Section V. Contract Performance, G. Dispute Resolution for Contract Performance, 1.* is revised and restated in its entirety as follows:

1. The PIHP shall exhaust the dispute processes described in this Section to dispute the imposition of intermediate sanctions, the assessment of liquidated damages, and/or for cause termination of the Contract whether pursuant to 42 C.F.R. § 438.708 or otherwise by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the PIHP under North Carolina or federal law or regulation.

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

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

V. <u>Modifications to Section VI. Contract Attachments</u>

Specific Attachments are modified as stated herein.

a. ***Section VI. First Revised and Restated Attachment C. Contractual Deliverable Schedule*** **is revised and restated in its entirety as** ***Section VI. Second Revised and Restated Attachment C. Contractual Deliverable Schedule*** **and is attached to this Amendment.**

b. ***Section VI. Second Revised and Restated Attachment D. PIHP Quality Metrics*** **is revised and restated in its entirety as** ***Section VI. Third Revised and Restated Attachment D. PIHP Quality Metrics*** **and is attached to this Amendment.**

c. ***Section VI. Second Revised and Restated Attachment E. PIHP Network Adequacy Standards*** **is revised and restated in its entirety as** ***Section VI. Third Revised and Restated Attachment E. PIHP Network Adequacy Standards*** **and is attached to this Amendment.**

d. ***Section VI. Second Revised and Restated Attachment F. Required Standard Provisions for PIHP and Provider Contracts*** **is revised and restated in its entirety as** ***Section VI. Third Revised and Restated Attachment F. Required Standard Provisions for PIHP and Provider Contracts*** **and is attached to this Amendment.**

e. ***Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements*** **is revised and restated in its entirety as** ***Section VI. Fifth Revised and Restated Attachment I. Reporting Requirements*** **and is attached to this Amendment.**

f. **Section** ***VI. Attachment L. Policies, 1. Medicaid Direct Prepaid Inpatient Health Plan Enrollment Policy is revised and restated in its entirety as Section VI. First Revised and Restated Attachment L. Policies, 1. Medicaid Direct Prepaid Inpatient Health Plan and is attached to this Amendment*****.**

g. **Section** ***VI. Second Revised and Restated Attachment L. Policies, 3. Uniform Credentialing and Re-credentialing Policy for Medicaid is revised and restated in its entirety as Section VI. Third Revised and Restated Attachment L. Policies, 3. Uniform Credentialing and Re-credentialing Policy for Medicaid and is attached to this Amendment.***

h. **Section** ***VI. First Revised and Restated Attachment L. Policies, 5. Tribal Payment Policy is revised and restated in its entirety as Section VI. Second Revised and Restated Attachment L. Policies, 5. Tribal Payment Policy and is attached to this Amendment*****.**

i. **Section** ***VI. First Revised and Restated Attachment L. Policies, 7. Approved [PIHP Name] In Lieu of Services*** **is revised and restated in its entirety as** ***Section VI. First/Second Revised and Restated Attachment L. Policies, 7. Approved [PIHP Name] In Lieu of Services*** **and is attached to this Amendment.**

j. Section *VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities* is revised and restated in its entirety as *Section VI. First Revised and Restated Attachment M. Addendum for Division of State Operated Healthcare Facilities* and is attached to this Amendment.

k. *Section VI. Third Revised and Restated Attachment N. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* is revised and restated in its entirety as *Section VI. Fourth Revised and Restated Attachment N. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* and is attached to this Amendment.

VI. Effective Date

This Amendment is effective July 1, 2024, unless otherwise explicitly stated herein, subject to approval by CMS.

VII. 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

CONTRACTOR NAME

_____ Date: _____

Contractor Signatory, Title

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

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

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

Section VI. Second Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule

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

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

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

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

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

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

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

Section VI. Second Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
33.	Member Educational Materials	Member	The date all written communications, call center scripts, websites or other communications directed to Members or potential Members, shall be sent to the Department for approval.	Yes	July 1, 2023
34.	Member Engagement and Marketing Plan for Historically Marginalized Populations	Communications and Stakeholder Engagement	The date the PIHP submits the Member Engagement and Marketing Plan for Historically Marginalized Populations to the Department.	Yes	January 6, 2023
35.	Member Enrollment and Disenrollment Policy	Member	The date the PIHP shall submit the Member Enrollment and Disenrollment Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
36.	Member Grievances and Appeals Policies	Member	The date the PIHP shall submit the PIHP Member Grievances and Appeals Policies to the Department.	Yes	Contract Execution + one hundred eighty (180) days
37.	Member Handbook	Member	The date the PIHP will submit the Member Handbook to the Department.	No	Contract Execution + ninety (90) days
38.	Member Incentive Program	Quality & Pop Health	The date the Member Incentive Program shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
39.	Member Mailing Policy	Member	The date the Member Mailing Policy shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
40.	Member Rights and Responsibilities Policy	Member	The date the PIHP shall submit the Member Rights and Responsibilities Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
41.	Member Service Line Script	Member	The date the listing of topics which scripts will address to the Department for approval.	Yes	Ninety (90) days after launch
42.	Member Welcome Packet	Member	The date the PIHP submits the Member Welcome Packet to the Department.	No	July 1, 2023
43.	Network Access Plan	Tailored Plan	The date the PIHP shall provide the Network Access Plan to the Department.	Yes	July 1, 2023
44.	Non-Discrimination Policy	Compliance	The date the PIHP will submit the Non-Discrimination Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
45.	Operating Plan	Tailored Plan	The date the PIHP's Operating Plan shall be submitted to the Department	Yes	June 30th Every Year
46.	Performance Improvement Projects	Quality & Pop Health	The date the PIHP shall submit the PIPs to the Department.	Yes	Contract Execution + Sixty (60) days

Section VI. Second Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
47.	Plan for Protection Against Insolvency	Finance	The date the PIHP shall submit a plan for protection against insolvency to the Department.	Yes	Contract Execution + one hundred eighty (180) days
48.	Provider Contract Templates	Tailored Plan	The date the PIHP shall provide Provider Contract Templates to the Department.	No	Contract Execution + thirty (30) days
49.	Provider Directory	Provider	The PIHP shall submit the Provider Directory to the Department.	Yes	Contract Execution + one hundred eighty (180) days
50.	Provider Grievances and Appeals Policies	Provider	The date the PIHP shall submit the PIHP Provider Grievances and Appeals Policies.	Yes	Contract Execution + Sixty (60) days
51.	Provider Hardship Payment policy	Finance	The PIHP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval.	Yes	Contract Execution + thirty (30) days
52.	Provider Manual	Provider	The date the PIHP shall provide the Provider Manual to the Department.	Yes	Contract Execution + ninety (90) days
53.	Provider Payment Monitoring and Audit Policy	Compliance	The PIHP shall submit policies and procedures to perform monitoring and auditing of provider payments to the Department.	Yes	Contract + one hundred eighty (180) days
54.	Provider Recruitment Materials	Provider	The PIHP shall submit recruitment materials to the Department for review at least ninety (90) Calendar Days before the proposed use of the material.	Yes	Ad-Hoc[6]
55.	Provider Support Service Line Script	Provider	The date the PIHP will submit to the Department, for approval, a listing of topics which scripts will address.	Yes	Ninety (90) days after launch
56.	Provider Training Materials	Provider	The PIHP shall provide education, specific to PIHP requirements, policies, including the Department's Medicaid Direct BH/I/DD Billing Guide, and procedures, training and technical assistance on all PIHP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.	Yes	Contract Execution + one hundred eighty (180) days
57.	Provider Training Plan	Provider	The date the PIHP shall provide the Provider Training Plan to the Department.	Yes	Contract Execution + one hundred eighty (180) days
58.	Provider Transition of Care Policy	Quality & Pop Health	The date the PIHP shall submit the Medicaid Provider Transition of Care Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days

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

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

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

Section VI. Second Revised and Restated Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	**Contractual Deliverable**	**Business Unit**	**Description**	**Leverage Tailored Plan Deliverable**	**Due Date**
73.	Third Party Administrator License (as applicable)	Tailored Plan	The date the PIHP shall submit their Third-Party Administrator's license if applicable.	Yes	Contract Execution + one hundred eighty (180) days
74.	Third-Party Liability Policy	Finance	The date the PIHP shall submit their Third-Party Liability Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
75.	Transition of Care Policy	Quality & Pop Health	The date the PIHP shall submit the Medicaid Transition of Care Policy to the Department.	Yes	Contract Execution + one hundred fifty (150) days
76.	Tribal Engagement Strategy (as applicable)	Member	The date the PIHP's Tribal Engagement Strategy Medicaid shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
77.	Utilization Management Policy	Benefits	The date the PIHP shall submit their UM Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
78.	Value-Added Services Request Form	Benefits	The PIHP shall submit to the Department the Value-Added Services Request form for approval.	No	Contract Execution + one hundred eighty (180) days
79.	VBP Assessment	Quality & Pop Health	The date the PIHP's first retrospective VBP Assessment shall be submitted to the Department.	Yes	September 30, 2025 and annually thereafter by end of Contract Year + ninety (90) days
80.	VBP Strategy	Quality & Pop Health	The date the PIHP shall submit the prospective VBP Strategy to the Department.	Yes	September 30, 2025 and annually thereafter by end of Contract Year + ninety (90) days
81.	Vendor Readiness Assessment Report	Technology	The date the PIHP shall provide the VRAR to the Department.	Yes	Contract Execution + thirty (30) days
82.	Website Content	Member	The date the PIHP shall submit Website Content to the Department.	Yes	Contract Execution + one hundred eighty (180) days
83.	Whistleblower Policy	Compliance	The date the PIHP shall submit the Whistleblower Policy related to whistleblower protections to the Department.	Yes	Contract Execution + one hundred eighty (180) days

The remainder of this page is intentionally left blank.

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

The PIHP will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in North Carolina's Medicaid Quality Measurement Technical Specifications Manual.

Updates to PIHP Quality Metrics

a. The Department will review and update the quality measures annually in January and reflect any updates in North Carolina's Medicaid Quality Measurement Technical Specifications Manual posted on the NC DHHS Quality Management and Improvement website as necessary, to align with the annual January update.
b. The PIHP shall begin to track the updated measures when posted annually in January.
c. The PIHP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with *Third Revised and Restated Section VI. Attachment D.* (e.g., for updates to the quality metrics posted in January 2024, the PIHP would report the results in June 2025).

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

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

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Section VI. Third Revised and Restated Attachment D. Table 1: Survey Measures and General Measures			
Ref #	**CBE #**	**Measure Name**	**Steward**
1.	Reserved		
2.	Reserved		
3.	Reserved		
4.	0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	NCQA
5	Reserved		
6	Reserved		
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	NCQA
8.	Reserved		
9.	2801	Use of Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
10.	Reserved		
11.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
12.	3175	Continuity of Pharmacotherapy for Opioid Use Disorder	USC
13.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	NCQA
14.	0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
15.	3489	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA

Section VI. Third Revised and Restated Attachment D. Table 2: Survey Measures and General Measures: Adult			
Ref #	**CBE #**	**Measure Name**	**Steward**
This entire table is reserved.			

Section VI. Third Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Proportion of Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
5.	Proportion of New Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of 1915(c) waiver Providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified 1915(c) waiver Providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with Innovations Waiver requirements.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Third Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			
14.	Percentage of beneficiaries reporting that their Individual Support Plans has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
16.	Proportion of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of individuals whose annual Individual Support Plans was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
18.	Proportion of individuals for whom an annual Individual Support Plan took place.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
19.	Number and percentage of waiver participants whose Individual Support Plans were revised, as applicable, by the Care Coordinator to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Reserved.			
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their Individual Support Plan within forty-five (45) Calendar Days of Individual Support Plan approval.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
22.	Proportion of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Third Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percentage of Innovations waiver beneficiary deaths where required PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November
26	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
27.	Percentage of beneficiaries who received appropriate medication.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Percentage of medication errors not resulting in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
30.	The percentage of survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Third Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
32.	Number and percentage of level 2 or 3 incidents where required PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
33.	Percentage of level 2 and 3 incidents reported within required timeframes.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Reserved.			
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Percentage of restrictive interventions (both restraint and seclusion) that did not result in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
37.	The proportion of claims paid by the PIHP for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
38.	The consistency of NC Innovations capitated rates (The proportion of the PIHP Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM).	NC DHHS	Annually Fiscal Year	November 1
39.	Reserved.			
40.	Reserved.			
41.	Reserved.			
42.	Reserved.			

Section VI. Third Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
43.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan.	NCDHHS	Annually Fiscal Year	November 1
44.	The percentage of Innovations Waiver beneficiaries age 21 and older who had a primary care or preventative care visit during the Innovations Waiver year.	NCDHHS	Annually Fiscal Year	November 1
45.	The percentage of Innovations Waiver beneficiaries under the age of 21 who had a primary care or preventative care visit during the Innovations Waiver year.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. Third Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	Number and percent of new PIHP members who have an independent evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number of PIHP members who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
3.	Number of PIHP members with Serious Mental Illness/Severe Emotional Disturbance who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
4.	Reserved.			
5.	Number of PIHP members with I/DD who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
6.	Number of PIHP members with TBI who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
7.	Number of PIHP members on the Innovations waitlist who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of independent re-evaluations completed at least annually for PIHP members using 1915(i) services.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

Section VI. Third Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
9.	Proportion of new independent evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of independent evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) services.	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of 1915(i) service providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of non-certified 1915(i) service providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
18.	Reserved.			
19.	Percentage of beneficiaries reporting that their Care Plan/Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
20.	Reserved.			
21.	Proportion of Care Plans/Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
22.	Reserved.			
23.	Reserved.			
24.	Reserved.			
25.	Reserved.			
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/Individual Support Plan within 45 days of Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Third Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
27.	Reserved.			
28.	Proportion of PIHP members using 1915(i) services reporting their Care Manager helps them to know what 1915(i) services are available.	NC DHHS	Annually Fiscal Year	November 1
29.	Proportion of PIHP members using 1915(i) services reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Reserved.			
32.	Reserved.			
33.	Reserved.			
34.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Quarterly July 1 –September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	Percentage of PIHP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death.	NC DHHS	Annually July 1 – June 30	November 1
36.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November
37.	Reserved.			
38.	Reserved.			
39.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident“ and "what can be done to prevent future occurrences" fields.	NC DHHS	Annually Fiscal Year	November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment.	NC DHHS	Quarterly July 1 – September 30	February 1 May 1

Section VI. Third Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
			October 1 – December 31 January 1 – March 31 April 1 – June 30	August 1 November 1
42.	The proportion of claims paid by the BH I/DD Tailored Plan for 1915(i) services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
43.	The percentage of continuously enrolled PIHP members using 1915(i) services (ages 3 and older) who also received a primary care or preventative health service.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
44.	The percentage of continuously enrolled PIHP members using 1915(i) services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled PIHP members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
46.	The percentage of continuously enrolled PIHP members using 1915(i) services ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

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

At a minimum, the PIHP Network shall consist of hospitals, physicians, advanced practice nurses, SUD and mental health treatment providers, TBI and I/DD providers, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section IV.H.1. Provider Network*.

For the purposes of this attachment and the PIHP Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties which will be covered by the applicable PIHP." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

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

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

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

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

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

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

Section VI. Third Revised and Restated Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**

		• Clinically Managed Population-Specific High Intensity Residential Program: contract with all designated CASPs
		• Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house:
		  ○ *Adult:* Access to ≥1 male and ≥1 female program per PIHP Region (Refer to 10A NCAC 27G .5600)8
		  ○ *Adolescent:* Access to ≥ 1 program per PIHP Region (refer to 10A NCAC 27G.5600)
		• Psychiatric *Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard	

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

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

4.	Inpatient BH Services	• *Inpatient Hospital – Adult*
		  • Acute care hospitals with adult inpatient psychiatric beds
		  • Medically managed intensive inpatient withdrawal management (Acute care hospitals with adult inpatient substance use beds)
		  • Medically managed intensive inpatient services (Acute care hospitals with adult inpatient substance use beds)
		• Inpatient Hospital – Adolescent / Children
		  • Acute care hospitals with adolescent inpatient psychiatric beds
		  • Medically managed intensive inpatient services (Acute care hospitals with adolescent inpatient substance use beds)
		  • Acute care hospitals with child inpatient psychiatric beds

5.	Partial Hospitalization	• Partial Hospitalization (adults and children)

Section VI. Third Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
6.	Residential Treatment Services	• Residential treatment facility services • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment): • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): • Clinically Managed Population-Specific High Intensity Residential Program • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house): • Psychiatric Residential Treatment Facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
7.	Community/Mobile Services	• Assertive Community Treatment (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports • Diagnostic Assessment
8.	1915(i) HCBS	• Supported Employment (for Members with I/DD and TBI) • Individual and Transitional Supports • Respite • Community Living and Supports • Community Transition • Individual Placement and Support (for Members with a qualifying mental health condition or SUD)
9.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment

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

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

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

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

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

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

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

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

ii. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.

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

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

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

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

1. In the case of the PIHP's insolvency, the contract must address:

a. Transition of administrative duties and records; and

b. Continuation of care when inpatient care is on-going in accordance with the requirements of the Contract. If the PIHP provides or arranges for the

delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.

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

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

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

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

1. That the provider shall not bill any member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the 'ember's own expense, as long as the provider has notified the member in advance that the PIHP may not cover or continue to cover specific services and the member requests to receive the service; and
2. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

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

1. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;
2. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and

3. Have a “no-reject policy” for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider’s competency to meet individual referral needs will be negotiated between the PIHP and the provider.

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

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

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

xii. Member Appeals and Grievances: The contract must address the provider’s obligation to cooperate with the member in regard to member appeals and grievance procedures.

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

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

xv. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the PIHP’s web-based billing process.

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

1. Performance feedback reports or information to the provider if compensation is related to efficiency criteria.

2. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.

3. Notification of changes in these requirements shall also be provided by the PIHP, allowing providers time to comply with such changes.

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

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

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

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

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

1. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PIHP.

2. The PIHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.

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

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

1. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.

2. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.

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

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

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

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

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

3. The contract shall include the following definitions:

   a. "Amendment" – Any change to the terms of a contract, including terms incorporated by reference, that modifies the fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order or by the PIHP Contract is not an amendment.

   b. "Contract" – A written agreement between an insurer and a Medicaid-enrolled provider for the provision of health care services by the provider on an in-network basis.

   c. "Health care provider" – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

4. Notice contact provisions - The contract shall address the following:

   a. All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.

   b. Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five (5) business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the

use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider.

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

   a. PIHP shall send any proposed contract amendment to the notice contact of a health care provider. The proposed amendment shall be dated, labeled "Amendment," signed by the PIHP, and include an effective date for the proposed amendment.

   b. A health care provider receiving a proposed amendment shall be given at least sixty (60) days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within sixty (60) days.

   c. If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the PIHP shall be entitled to terminate the contract upon sixty (60) days written notice to the health care provider.

   d. A health care provider and the PIHP may negotiate contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.

6. Policies and Procedures: The contract shall address the following:

   a. PIHP's policies and procedures applicable to contracted health care providers shall be incorporated into the PIHP's Provider Manual or posted to the PIHP's website.

   b. The policies and procedures of the PIHP shall not conflict with or override any term of a contract, including contract fee schedules.

xxvi. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. The PIHP shall ensure that Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

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

a PIHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

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

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

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

xxxi. Provider Manual: The PIHP shall include Department-developed standard terms and conditions included in the Tailored Care Management (TCM) Provider Manual Addendum: Healthy Opportunities Pilot Standard Terms & Conditions for AMH+s/CMAs in its contracts with Designated Pilot Care Management Entities.

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

i. Compliance with state and federal laws

The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the PIHP's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a

state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [PIHP's] contract with NC DHHS could result in liability for money damages, including civil or criminal penalties and sanctions under state and/or federal law.

ii. Hold Member Harmless

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

iii. Liability

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

iv. Non-discrimination Equitable Treatment of Members

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

v. Department authority related to the Medicaid program

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

vi. Access to Provider Records

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

1. The United States Department of Health and Human Services or its designee;
2. The Comptroller General of the United States or its designee;

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

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

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

vii. Prompt Claim Payments.

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

The [Provider] shall submit all claims for a date of service before BH I/DD Tailored Plan Launch, to the [PIHP] for processing and payments within one-hundred-eighty (180) Calendar Days from the date of covered service or discharge (whichever is later). When a Member is retroactively enrolled, the [PIHP] shall not limit the time in which claims may be submitted by the [Provider] to fewer than one hundred eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims.

The [Provider] shall submit all claims with a date of service on or after BH I/DD Tailored Plan Launch, to the [PIHP] for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service or discharge (whichever is later). When a Member is retroactively enrolled, the [PIHP] shall not limit the time in which claims may be submitted by the [Provider] to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider or health care provider facility claims.

However, the [Provider's] failure to submit a claim within these timeframes 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.

For Medical claims (including behavioral health):

1. The [PIHP] 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 [PIHP] 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 [PIHP] shall implement the capability for EDI 277 and electronic method (portal or email) no later than BH/IDD Tailored Plan Launch if approved by the Department. If an extension is needed, the [PIHP] may submit a request to the Department's Contract Administrator including the proposed implementation timeline and an explanation of how provider abrasion will be minimized during the extended implementation period.
2. The [PIHP] 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. Reserved.
4. Reserved.
5. Reserved.
6. Reserved.
7. Failure to pay a clean claim within thirty (30) days of receipt will result in the [PIHP] paying the [Provider] a penalty on the portion of the claim payment that is late equal to one (1) percent for each Calendar Day following the date the claim should have been paid or was underpaid. All references to penalty(ies) paid to a Provider as a result of late payments to Providers are hereby stricken effective July 1, 2024. The PIHP shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. 58-3-225(k).
8. The [PIHP] shall pay the interest and penalties according to paragraphs 7. and 10. of this subsection and shall not require the [Provider] to request the interest or the liquidated damages. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
9. If the [PIHP] fails to pay a clean claim in full pursuant to this provision, the [PIHP] shall pay the [Provider] interest and penalties consistent with paragraphs 7. and 10. of this subsection. Late Payments will bear interest on the portion of the claim payment that is late at the annual rate of eighteen (18) percent beginning on the first day following the date that the claim should have been paid or was underpaid.
10. For purposes of claims payment, the [PIHP] shall be deemed to have paid the claim as of the Date of Payment, and the [PIHP] shall be deemed to have denied the claim as of the date the remittance advice is sent to the [Provider]. The

[PIHP] defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to the [Provider] or the date a paper check is mailed to the [Provider].

viii. Contract Effective Date.

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

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

ix. Tobacco-free Policy.

i. Providers who 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 Partial Tobacco-Free Policy

Beginning July 1, 2025, contracts with Intermediate care facilities for adults with intellectual disabilities 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; and.
    b. Prohibit staff/employees from using tobacco products anywhere on the property.

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

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

iii. Providers subject to Full Tobacco-Free Policy

Starting July 1, 2025, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

[Provi*der] 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 VI. Fifth Revised and Restated Attachment I. Reporting Requirements

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

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

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

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
A. Administration and Management		
1. PIHP Operating Report	Annual report of each entity identified under the PIHP Operating Report, providing evidence of PIHP oversight activities and entity performance (i.e., metrics, CAPs, sanctions).	Annually
B. Members		
1. Member Services Quality Assurance Report	Quarterly report of survey results which measures Member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
2. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PIHP including the total number of appeal and grievance requests filed with the PIHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Quarterly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
3. PIHP Enrollment Summary Report	Monthly summary report highlighting key member enrollment activities, consistent with 42 C.F.R. § 438.–6(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid eligibility category, number of Member welcome packets sent, and time to distribute Member welcome packets.	Monthly
4. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
5. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
6. CIE Data Collection Tool	Report generated by completion of the CIE Data Collection Tool provided by the Department, regarding individuals receiving Adult Developmental Vocational Program (ADVP) services or any In-Lieu of Services (ILOS) inclusive of activities that promote engagement in competitive integrated employment (CIE) or in meaningful day activities supporting competitive integrated employment. This report includes without limitation and as applicable the following information regarding the individuals: involvement in post-secondary education, employment assessments, career planning, Supported Employment, Informed Choice Decision Making, engagement in CIE, and the Member's hire date. For members engaged in CIE, the following data is also included: wages earned, and average hours worked per week.	Quarterly
C. Benefits		
1. Institute of Mental Disease (IMD) Report	Bi-Weekly summary of Members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-Weekly
2. EPSDT Reports	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.	Quarterly
3. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver reserved capacity, and list of Members on the Registry of Unmet Needs (waiting list). Report can be included with TP Innovations Waiver Slot and Waiting List Report.	Monthly
4. Reserved.		
5. Monthly CWCN	Monthly report containing the names and member Medicaid ID numbers, and all data fields as outlined in the	Monthly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	approved DHHS CWCN data template of members identified as CWCN per the PIHP Plan's Region.	
6. Ongoing Transitions of Care Status Reports	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the PIHP on an ongoing basis.	Monthly
7. Innovations Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
8. TBI Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
9. 1915(i) Performance Measures Report	This report is to demonstrate ongoing compliance with annual/semi-annual/quarterly 1915(i) state plan performance measures.	Quarterly
10. Emergency Department Boarding for Children	Weekly report of all Members under age eighteen (18) who are boarding in an Emergency Department setting awaiting medically necessary treatment for Behavioral Health, IDD, or TBI services. For any Member in the Emergency Department over thirty (30) consecutive hours, document escalation to appropriate parties including but not limited to the PIHP Clinical Director or designee.	Weekly
11. Daily Reporting on Community Integration Services and Supports	Daily report of information on community integration services (e.g., housing, in-reach and transition, diversion, Assertive Community Treatment (ACT), CST, supported employment, and other services) for members SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Transition to Community Living Database (TCLD), or other systems determined by the State.	Daily
12. Daily Reporting on Supportive Housing Rental Subsidies and Leases	Daily reporting of rental subsidy and leasing information and updates for individuals including , but not limited to, Members with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) platform or other systems determined by the State.	Daily
13. 1915 Service Authorization Report	Authorized and billed 1915(i), 1915(c), 1915(b)(3) services for community living supports, community networking, supported employment, and supported living.	Quarterly
14. Service Associated Request Report	PIHPs decision regarding the service requested on the Request to Move: Provider Form.	Monthly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
15. Brain Injury Screening Report	Quarterly report of Members screened by the PIHPs for brain injury including call date, completion of status screening, age of injury, cause of injury, county, insurance coverage, self-identification status, co-occurring diagnoses, and referrals initiated. The screening data is utilized to analyze the number of Members living with brain injuries, identify prevalence rates, locate geographic concentrations, and aid in developing targeted service delivery strategies. The screening data is used to inform on the number of individuals living with brain injury, prevalence and any geographic concentrations, as well as support the development of targeted service delivery needs and future implementation of the TBI waiver as directed in S.L. 2023-134, Section 9e.16(d).	Quarterly
D. Care Management and Care Coordination		
1. Care Needs Screening Report	Quarterly report of Member screening results, including Healthy Opportunity & Care Needs Screening of Members who have opted out of TCM or ineligible TCM due to receipt of a duplicative service .	Quarterly
2. Reserved.		
3. TCM Provider Status Change Report	Monthly reporting on tracking TCM provider status changes and the associated decision reasoning.	Monthly
4. TCM Provider Contracting and Integration Report	Weekly TCM Provider contracting and integration status report.	Weekly
E. In-Reach and Transitions		
1. IDD In Reach, Diversion, Transition Activity Report	This report is for IDD members related to: <u>In Reach:</u> Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). <u>Diversion:</u> Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center,	Quarterly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). <u>Transition:</u> Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
2. SED In Reach, Diversion, Transition Activity Report	This report is for SED members related to: <u>In Reach:</u> Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). <u>Diversion:</u> Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). <u>Transition:</u> Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
3. TBI In Reach, Diversion,	This report is for TBI members related to:	Quarterly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
Transition Activity Report	In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH)	
F. Providers		
1. Reserved.		
2. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
3. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.	Annually
4. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
5. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and corresponding statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
6. Reserved.		
7. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
8. Capitation Reconciliation Report	Monthly report to inform the State of any capitation-related payment discrepancies observed. PIHPs will include records of members where no payment was received from the State or payment received differed from the amount expected. PIHPs will only include member records with discrepancies on this report to the State. The PIHP Capitation Reconciliation Report will be submitted on a monthly cadence. PIHPs will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
9. Reserved		
10. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Quarterly
11. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
12. Reserved.		
G.Quality and Value		
1. Reserved.		
2. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
3. Quality Measures Report	Annual PIHP performance on quality measures.	Annually
4. Reserved.		
5. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
6. Reserved.		
H. Stakeholder Engagement		
1. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PIHP to collaborate with county organizations to address issues by county/Region.	Monthly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
2. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
3. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.	Quarterly
I. Program Administration		
1. Reserved		
2. Reserved		
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
J. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the PIHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential fraud, and actual waste and abuse by Participating Providers, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential fraud, and actual waste and abuse by Members, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Reserved.		
6. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly
9. Recipient Explanation of Medical Benefit (REOMB)	The Plans are responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems pursuant to *Section IV. C. Compliance, 5.* The Plans send REOMBs to random sample of members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the member(s). The communication includes the Provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The Plans are required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.	Quarterly (For report submission due dates please refer to the NCTP Report Guide)
K. Financial Requirements		
1. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted monthly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others. Audited Financial Statements submitted as part of this reporting packet must comply with 42 C.F.R. 438.3(m).	Monthly
2. PIHP Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the PIHP template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
3. Claims Monitoring Report*	Monthly summary of BH claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional or, institutional. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period. Note: Ad-hoc upon request. Ad hoc report will be requested	Monthly

Section VI. Fifth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	no less than ten (10) Calendar Days in advance or mutually agreed upon timeframe . *For BH claims only	
4. Payer Initiated Claim Adjustment Report	Ad hoc report required in the event the State deems necessary or a provider escalates grievance related to PIHP claim adjustment processing. The PIHP must complete required information within the report for the Department to validate appropriate claim adjustment was complete.	Ad hoc

Section VI. Fifth Revised and Restated Attachment I. Table 2: PIHP Data Extracts		
PIHP Report Name	**PIHP Report Description**	**Frequency**
A. Members		
1. PIHP Enrollment Extract	Weekly detail report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets.	Weekly
2. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of Adverse Benefit Determination issued by the PIHP to a Member and each grievance received by PIHP from Members.	Daily
3. Monthly Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. *Note* If the date the extract is being submitted is prior to July 1, 2022, the extract would include member eligibility as of July 1, 2022.	Monthly
B. Benefits and Care Management		
1. Medical Prior Authorization Extract*	Weekly extract providing information on behavioral health prior approval requests by individual Member, service type, determination date, and approval status. *For BH prior authorization requests only	Weekly
2. Care Management Reason Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly
C. Providers		
1. Reserved.		

Section VI. Fifth Revised and Restated Attachment I. Table 3: PIHP Reporting Requirements for Healthy Opportunities Pilot (Required Only for PIHPs Participating in the Pilot)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
1. Healthy Opportunities Pilot Key Metrics Report	Report of Healthy Opportunities Pilot key metrics, including at a minimum: Members served, services used, total service delivery costs, and Member cost and utilization metrics related to the Healthy Opportunities Pilot.	Quarterly
2. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PIHP may submit if the Department notifies the PIHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PIHP's anticipated spending through the remainder of the Pilot service delivery year.	Optional, or at the discretion of the PIHP
3. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly report of PIHP Pilot service delivery spending.	Monthly
4. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PIHP Pilot administrative fund spending.	Quarterly
5. Reserved.		

Section VI. Fifth Revised and Restated Attachment I. Table 4: TCL Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
1. TCL Housing Entry and Exit Report	Report on TCL individuals who are entering or exiting the TCL program, including tracking of reasonable accommodations submitted, disposition on behalf of TCL members, reasons for separations	Monthly – due 15th of the month, or the first Business Day following the 15th if the 15th falls on a weekend or holiday.
2. TCL Annual Service Capacity Report	Capacity analysis for ACT, CST, TMS, Crisis Services and IPS. Includes identification of barriers and projects/steps implemented to remove barriers	Annually Fiscal Year 2025

3. TCL Housing Performance Plan Measures Reporting Template	Report tracking TCL Housing Performance Plan Measures. This report indicates measures for each PHIP per quarter based on their reported Tier 1, Tier 2 Expectations, results provided by the PIHP and the Department's verified results.	Quarterly
4. TCL IPS Population and Utilization Report	Report on IPS TCL population and utilization of the service, includes updates on IPS cohorts (as part of ACT and standalone IPS)	Monthly
5. TCL IPS Strategic Plan Progress Report	Report on TCL Strategic Plan progress, includes data required as part of the Department approved IPS Strategic Plan (as part of ACT and standalone IPS)	Quarterly

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Section VI. Attachment L. Policies, 1. First Revised and Restated Medicaid Direct Prepaid Inpatient Health Plan Enrollment Policy

1. Medicaid Direct Prepaid Inpatient Health Plan Enrollment Policy

a. Scope

i. The North Carolina Medicaid Direct Prepaid Inpatient Health Plan (PIHP) Enrollment Policy outlines the expectations of the Department and the PIHP in the enrollment of beneficiaries into PIHPs.

b. Identification of Beneficiaries Eligible for a PIHP

i. In accordance with N.C. Gen. Stat. § 108D-40(a)(13) and 108D-60(b) as amended by S.L. 2021-642, s. 3.4A, the Department will identify beneficiaries who are members of the following eligibility groups who are excluded or delayed from Medicaid Managed Care and are eligible for the PIHP upon its launch.

1. Beneficiaries who reside in a nursing facility and have so resided for a period of 90 days or longer.
2. Beneficiaries who are in one of the following categories will be enrolled in the PIHP until the launch of the Foster Care Plan:
3. Enrolled in the foster care system;
4. Receiving Title IV-E adoption assistance; or
5. Under the age of twenty-six (26) and formerly were in the foster care system.
6. Beneficiaries who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing except for beneficiaries enrolled in the Innovations waiver.
7. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations waiver excluding federally recognized tribal members
8. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the TBI waiver excluding federally recognized tribal members;
9. Presumptively eligible beneficiaries, during the period of presumptive eligibility, excluding presumptive eligibility for pregnant women.
10. Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations and TBI waivers.
11. Beneficiaries being served through CAP/C.
12. Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice).

ii. In accordance with N.C. Gen. Stat. § 108D-40(a)(5) beneficiaries who are members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are eligible for the PIHP.

1. These beneficiaries will default to the Tribal Option for care management if they reside in a county where the Tribal Option is offered and will default to the PIHP for BH I/DD and TBI services and NC Medicaid Direct for physical health services, pharmacy, and State Plan LTSS.
2. These beneficiaries will have the choice to enroll in a Standard Plan or BH I/DD Tailored Plan (if eligible).
3. More details of these options can be found in Section *IV.H.1 Tribal Member Services and Indian Health Care Providers* (42 C.F.R. § 438.14).

iii. The Department shall auto-assign beneficiaries who are part of a group that is delayed or excluded from Medicaid Managed Care as described in Section V.B.E. (ii) to the PIHP that is responsible for their county of Medicaid eligibility through an 834 eligibility file.
iv. The PIHP shall accept Member Enrollment and effectuate coverage on the first day of the month in which Medicaid eligibility is determined.
v. In accordance with NCGS § 108D-40(a), the following beneficiaries are eligible for enrollment in the PIHP:
    1. Beneficiaries who are inmates of prisons, as provided in N.C.G.S. § 108D-40(a)(9).
    2. Beneficiaries who are residing in carceral settings other than prisons, as provided in N.C.G.S. § 108D-40(a)(9a).

c. Medicaid Eligibility Redeterminations

i. At a Member's annual Medicaid renewal, if a Member is redetermined eligible for Medicaid and continues to be eligible for a PIHP, the Department will auto-assign the Member into the same PIHP from the prior eligibility year, provided that the Member's Medicaid county of eligibility remains in the same PIHP Region.
    1. If the Member's eligibility has moved to a county that is part of a different PIHP Region, the Department will auto-assign the Member into the PIHP in the Member's new county of eligibility on the first day of the month following the change in the Member's county of eligibility.
ii. If a Member is determined based on data reviews to no longer be part of a group that is delayed or excluded from managed care, the Department will refer the Member to the Enrollment Broker for enrollment in a Standard Plan or BH I/DD Tailored Plan.
iii. If a Member is determined to no longer be eligible for Medicaid, the Member will be notified and disenrolled from the PIHP by the Department.

d. Special Enrollment Cases

i. Exempt populations
    1. Exempt populations as defined in *Section II.A* that are PIHP Medicaid Direct eligible will be able to enroll in PIHPs.
    2. The Enrollment Broker will provide choice counseling to exempt populations and support NC Medicaid Direct, PIHP, and EBCI Tribal Option (as applicable).
    3. If a beneficiary in an exempt population selects NC Medicaid Direct, the Enrollment Broker will transmit the PIHP selection to the Department. The Department will transmit PIHP selection to the PIHP through an 834 eligibility file.
    4. If a beneficiary in an exempt population elects to move from NC Medicaid Direct and a PIHP to a Standard Plan, BH I/DD Tailored Plan or other delivery system (such as the EBCI Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by Standard Plan, BH I/DD Tailored Plan, or other delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan, BH I/DD Tailored Plan, or delivery system.[1]
    5. Beneficiaries who are eligible for the EBCI Tribal Option will be permitted to transfer to the EBCI Tribal Option from any delivery system at redetermination and at any point during the year.
ii. Disenrollment from PIHPs required by the Department

[1] There may be instances (e.g., an urgent medical need), as determined by the Department and based on the beneficiary's needs, in which enrollment in the new PIHP or the new delivery system may become effective sooner, including mid-month.

1. The Department may disenroll a Member from the PIHP for any of the following reasons:

a. Loss of eligibility

i. If the Department determines that a member is no longer eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the PIHP. The disenrollment effective date will be the last date of the Member's Medicaid eligibility.

ii. If a Member is disenrolled from a PIHP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the PIHP upon reenrollment in Medicaid. [2]

b. Change in Medicaid eligibility category

i. If the Department determines that a Member is no longer eligible for the PIHP because they are no longer part of an Exempt, excluded or delayed population as described defined in Section II.A, the Member will be notified by the Department and the Department will disenroll the Member from the PIHP. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.

c. Change in county of Medicaid Administration

i. If the Department determines that the Member's county of Medicaid Administration has changed to a county outside the PIHP's catchment area, the Member will be notified by the Department and the Department will disenroll the Member from the PIHP and auto-enroll the member into the PIHP that is responsible for the new county of residence. The disenrollment date will be the first of the month following the change in the Member's county of residence.

iii. In accordance with 42 C.F.R. § 438.56(f), Members, or an authorized representative, may appeal disenrollment determinations made by the Department through an appeals process defined by the Department.

e. PIHP Enrollment Policy Changes

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes.

[2] 42 C.F.R. § 438.56(g).

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

a. Background

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

b. Scope

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

c. Policy Statement

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

d. Centralized Provider Enrollment and Credentialing

i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:
   1. The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid Direct for BH and I/DD Services.
      a. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.
      b. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.
   2. The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid Services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).

3. The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the NCQA as the Plan accrediting organization. The applicable data and processing standards shall be consistent with current waivers or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.
4. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid Enrolled provider, with the application serving for enrollment as PIHP providers.
    a. The Department shall not mandate PIHP providers enrolled with the State to provide State-funded services.
5. Providers will be reverified and recredentialed as permitted, by the Department in the Contract.
6. A PIHP shall use the PIHP Provider Manual to outline the process for contracting with Providers who have met the Department's Objective Quality Standards and how the PIHP will routinely evaluate its Provider Network to confirm a provider's continue active status as a Medicaid Enrolled provider in accordance with the standards contained in this Policy.
7. The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers. The PIHP shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

e. Provider Credentialing and Re-credentialing Policy

i. The PIHP shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The PIHP's polices and procedures, at a minimum, must:
    1. Meet the requirements specified in 42 C.F.R. § 438.214;
    2. Meet the requirements specified in this Contract;
    3. Follow the Department's Uniform Credentialing and Re-credentialing Policy and any applicable requirements from the Contract, and address acute, mental health, substance use disorders, and long-term services and supports providers;
    4. Establish that the PIHP shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.
    5. Establish a documented process for determining if a provider is an active Medicaid Enrolled provider and therefore eligible for contracting;
    6. Prohibit PIHP from discriminating against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
    7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

8. Prohibit PIHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
9. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and
10. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH and I/DD services. At a minimum, these standards shall assess a provider's ability to deliver care.
11. Describe the information that providers will be requested to submit as part of the contracting process.
12. Describe the process by which the PIHP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).
13. If PIHP requires a provider to submit additional information as part of its contracting process, the PIHP's policy shall include a description of all such information.
14. The Department shall re-credential providers as follows:
    a. The Department shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
    b. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.
15. PIHP shall follow the Department's Uniform Credentialing and Re-credentialing Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.
16. PIHP shall have discretion to make network contracting decisions consistent with the Policy.

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Section VI. Attachment L. Policies, 5. Second Revised and Restated Tribal Payment Policy

1) Background

This Tribal Payment Policy outlines the expectations of the Department regarding payment for covered services to Indian Health Care Providers (IHCP) by a PIHP.

Indian Health Care Provider (IHCP) refers to a "health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by state recognized tribes are not considered IHCPs.

In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a "Tribal Provider Attestation." This "Tribal Provider Attestation" letter from the EBCI Chief's office shall be submitted to NC DHHS as part of the NC DHHS centralized credentialing process. The information about tribal providers will be shared with PIHPs through DHB's existing process

2) Scope

This Policy applies to PIHPs and covers payment for covered services provided by IHCPs and other Tribal providers. This Policy shall apply to all IHCPs/Tribal providers regardless of the provider's contracting status.

3) Policy Statement

The PIHP shall implement:

a) Claim Submission

i) Cherokee Indian Hospital (CIHA) will bill for inpatient and outpatient services and will be paid for these services in accordance with current NC Medicaid requirements.

ii) Other Indian Health Service (IHS)/Tribal/Urban (I/T/U) providers/Tribal providers will submit claims utilizing formats currently utilized when billing NC Tracks in fee for service.

b) Payment

i) PIHP shall comply with PIHP Contract Section IV.H.4.f-g., *Indian Health Care Provider (IHCP) Payments*

(1) In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the PIHP shall reimburse IHCPs as follows:

(a) Those that are not enrolled as an FQHC, regardless of whether they participate in the PIHP's network:

(i) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or

(ii) The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.

(2) The PIHP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

ii) PIHP shall comply with PIHP Contract *Section IV.D.1., Engagement with Tribes* with regard to providing and maintaining a point of contact for IHCP billing issues to the Department.

(1) The PIHP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

c) Prompt Pay

i) PIHP shall comply with PIHP Contract *Section IV.J.1 Claims*.

(1) The PIHP shall promptly pay Clean Claims, regardless of provider contracting status. The PIHP shall reimburse medical providers in a timely and accurate manner when a clean medical claim is received.

(a) Claims

(i) The PIHP shall, within eighteen (18) calendar days of receiving a Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.

(ii) The PIHP shall pay or deny a Clean Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

(iii) A Pended Claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

(iv) For purposes of claims payment, the PIHP shall be deemed to have paid the claim as of the Date of Payment, and the PIHP shall be deemed to have denied the claim as of the date the remittance advice is sent.

(2) The PIHP shall reprocess claims in a timely and accurate manner as described in this Section (including interest and penalties consistent with paragraph (4) of this subsection, if applicable).

(3) Claim Submission Timeframes:

(a) For any claims with a date of service prior to BH I/DD Tailored Plan Launch:

(i) The PIHP may require that claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the Member's discharge from the facility. However, the PIHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the PIHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

(a) When a member is retroactively enrolled, the PIHP may not limit the time in which claims may be submitted to fewer than one hundred

eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims.

(b) When a claim requires financial eligibility determination, the PIHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date the patient monthly liability (PML) is determined for health care provider and health care provider facility claims.

(b) For any claims with a date of service on or after BH I/DD Tailored Plan Launch:

(i) The PIHP may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within three hundred sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. However, the PIHP may not limit the time in which health care provider and health care facility claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days. Unless otherwise agreed to by the PIHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

(a) When a member is retroactively enrolled, the PIHP may not limit the time in which claims may be submitted to fewer than three hundred and sixty-five (365) Calendar Days from the date of enrollment for health care provider and health care provider facility claims.

(b) When a claim requires financial eligibility determination, the PIHP may not limit the time in which claims may be submitted to fewer than three hundred and sixty-five (365) Calendar Days from the date the patient monthly liability (PML) is determined for health care provider and health care provider facility claims.

(4) Interest and Penalties

(a) The PIHP shall pay interest to the Provider on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract.

(b) In addition to the interest on late payments required by this Section, the PIHP shall pay to the Provider, including, but not limited to, AMH+ practices and CMAs, a penalty on the portion of the claim payment that is late equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid or was underpaid as specified in the Contract. All references to penalty(ies) paid to a Provider as a result of late payments to a Provider are hereby stricken effective July 1, 2024.

(c) The PIHP shall not be subject to interest or penalty payments if its failure to comply is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the PIHP's reasonable control, including an act of God, insurrection, strike, fire, or power outages. Also, the PIHP is not subject to interest or penalty payments if the PIHP has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(5) The PIHP shall maintain written or electronic records of its activities under the prompt pay standards, including records of when each claim was received, paid, denied, or pended, and the PIHP's review and handling of each claim under this section, sufficient to demonstrate compliance with the prompt pay standards.

(6) For purposes of actions which must be taken by a PIHP as found in PIHP Contract *Section IV.J.1 Claims,* if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

d) Other Payment Sources

i) Due to the change in payer hierarchy, the PIHP will allow for timely payment for Tribal providers without delaying payments due to coordination of benefits. Medicare and Medicaid are payers of first resort for Tribal members and providers. Tribal and IHS funds are payers of last resort.

ii) Tribal self-funded insurance is not a billable source for the Eastern Band of Cherokee Indians (EBCI), and therefore, PIHP shall not attempt to coordinate benefits with that plan.

e) Sovereignty

i) No contractual relationship shall deny or alter tribal sovereignty.

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Section VI. First/Second Revised and Restated Attachment L. Policies, 7. Approved PIHP Name In Lieu of Services

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the Medicaid State Plans or otherwise covered by this Contract but have been determined by the Department to be medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.

The PIHP may cover for Members, services or settings that are in lieu of services or settings covered under the State Plans as follows:

1. The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute based on documentation provided to the Department by the PIHP demonstrating such cost effectiveness and clinical effectiveness;
2. The PIHP shall ensure that Members are provided the rights outlined in *Section V.F.1.g. In Lieu of Services* for all approved In Lieu of Services;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the PIHP; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise.

In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process. In accordance with *Section IV.F. Benefits*, the following In Lieu of Services have been approved by the Department:

ILOS that have received conditional approval from the Department are effective through December 31, 2023. If the PIHP wishes to continue offering the conditionally approved ILOS beyond December 31, 2023, the PIHP shall resubmit the Department's standardized ILOS Service Request Form at least ninety (90) Calendar Days prior to December 31, 2023.

Attachment L. 7. First Revised and Restated Approved Alliance Health In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Child Assertive Community Treatment	Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting.	Psychiatric Residential Treatment Facility (PRTF) Level III Group Home	Eligible population includes youth with a primary mental health diagnosis. High risk for out of home residential treatment due to history of multiple hospitalizations, multiple placements in residential treatment. Symptoms at a severity level where PRTF or other intensive residential treatment.	H0040 U5 HA
In Home Therapy Services	Children and adolescents in need of individual and family therapy services, parenting and coping strategies due to complex psychosocial situations and/or multisystem involvement.	Intensive In-Home Services (IIHS)	Eligible population is for children and adolescents ages 3-20 years of age in need of individual and family therapy services, parenting, and coping skills practice in their environment, as well as some coordination of care due to complex psychosocial situations and/or multisystem involvement.	H2022 HE U5 H2022 TS U5
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities, FCT treats the youth and his/her family through individualized therapeutic interventions.	Residential Level II Family Type (TFC) Psychiatric Residential Treatment Facility (PRTF)	Eligible population involves a step down from a higher level of care, DSS involvement in the last year, Juvenile Justice involvement in the last 6 months, behavioral health Emergency Room visit and/or hospitalization in the last 6 months, multiple school suspensions within the past year, and crisis intervention in the last 6 months.	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4

Transitional Youth Services (TYS)	The Transitional Youth Services Program is a home and community-based Outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently.	Residential Level II Family Type (TFC) Level III Residential Facility Services	Eligible population is Members who are leaving the foster care or juvenile Justice Systems, or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood.	H2022 U5
Behavioral Health Crisis Assessment and Intervention (BHCAI)	BH CAI is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting.	Inpatient Psychiatric Hospitalization Facility Based Crisis Behavioral Health Urgent Care (BHUC)	Eligible population are Members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.	T2016 U5 or T2016 U6
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders.	Emergency Depts Inpatient Psychiatric Hospitalization	Medicaid members with Mental Health (MH) and Substance Use Disorders (SUD) who require inpatient behavioral health treatment.	RC 0160
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care DocuSign Envelope ID: 1C2730A0-0635-487A-88F6-DC0BC6D74C71 #30-2022-007-DHB-1 Amendment 1 Page 141 of 148 to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious	Residential Level II Family Type (TFC) Residential Treatment Services Level II Group Home	Eligible population Children, youth, and young adults with Serious Emotional Disturbance (SED) that have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and substance use problems, Involved in (or history of) multiple child-serving systems (e.g., child welfare, juvenile justice).	H0032 - U5

	emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW.			
Short Term Residential Stabilization	Short Term Residential Stabilization (STRS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active habilitation services and supports to assist them with skill acquisition to live as independently as possible in the community. STRS is a community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD).	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Facility Based Crisis	Eligible population includes individuals in need of and receiving comprehensive and intensive habilitative supports– aggressive, consistent implementation of a program of specialized and generic habilitative training. Medicaid eligible Age 21 or older Meet ICF-IID eligibility criteria and/or the definition of developmental disability.	T2016 TF U5
Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis (Residential Services – Complex Needs)	Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral characteristics.	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Psychiatric Residential Treatment Facility (PRTF)	Eligible population includes Individuals with I/DD diagnosis and meet the ICF/IDD level of care consistent with the Innovations Wavier. The individual also has co-occurring MH diagnosis or significant behavioral challenges for which services and supports require significant experience and expertise in dual diagnosis.	H0018 HA

Attachment L. 7. First Revised and Restated Approved Partners Health Management In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Rapid Response	Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing Agency or licensed alternative family living (AFL) homes that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment, and prevent or minimize the need for out-of-home placements.	Emergency Department-Family Based Crisis (ED/FBC) Psychiatric Residential Treatment Facility (PRTF)	Target population includes youth are presenting in crisis but do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and executed.	S9484 U5 (low) S9484 HK U5 (high)
In Home Therapy Services	In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient	Intensive In-Home (IIHS)	Target population includes children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement.	H2022 HE U5 U1 H2022 HE U5 TS

	services alone are not sufficient to address the needs and prevent future incidents.			
Behavioral Health Urgent Care (BHUC)	Behavioral Health Urgent Care (BHUC) A designated intervention/treatment location, known as a Behavioral Health Urgent Care (BHUC) that is an alternative to any community hospital Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referral.	Emergency Department Visit Inpatient Psychiatric Hospital Admission	Target population includes MH, SUD, co-occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards.	T2016 U5
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders	Inpatient Psychiatric Hospitalization	Target population includes members aged 21-64 enrolled in Medicaid with Mental Health (MH) or Substance Use Disorders (SUD) who require inpatient treatment	RC 0160
Rapid Care Services Children and Adults with Mental Illness and/or Substance use disorders	Rapid Care Services allow time for extended assessment which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member.	Emergency Department Visit Inpatient Psychiatric Hospitalization	Target population includes an alternative to Emergency Room and Inpatient Psychiatric Hospitalization for eligible individuals who have a mental illness and/or substance use disorder diagnoses.	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents	Intensive In-Home Residential Treatment Level III	Target population includes a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4

	and their families. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.		reference material), other than a sole diagnosis of intellectual and developmental disability;	
Residential Services-Complex Need	Residential Services – Complex Needs is a short-term residential treatment service focused on treatment of member with cooccurring conditions and complex presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.	Psychiatric Residential Treatment Facility (PRTF) Inpatient Psychiatric Hospitalization	Target population includes children and adults, ages 5 through 21 with either: Primary mental health (MH) diagnosis and I/DD diagnosis or borderline intellectual functioning with traits that inhibit optimal functioning OR Primary I/DD diagnosis with co-occurring MH diagnosis.	H0018 HA
Individual Rehabilitation, Coordination, & Support Services	The purpose of this service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the individual's living, learning, social, and work environments. IRCS is a skill building service, not a form of psychotherapy or counseling.	Psychosocial Rehabilitation	Target population includes individuals that received a comprehensive clinical assessment and has been diagnosed with serious and persistent mental illness.	H2017 U5
High Fidelity Wraparound (HFW)	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, familydriven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, physical health, child welfare, juvenile/criminal justice, and education), experience serious emotional or behavioral	Psychiatric Residential Treatment Facility (PRTF) Residential Level III Placement	Target population includes Youth with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability AND Based on the current comprehensive clinical assessment including	H0032 - U5

	difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in PRTFs or other institutional settings, and/or are aging out of Department of Social Services (DSS) care.		the use of the CALOCUS or CANS, functional impairment is demonstrated to indicate this level of service.	
Young Adults in Transition	The Young Adults in Transition service is a home and community-based outpatient intervention that supports transition-age members (ages 16-24) with behavioral health diagnoses of mental health disorder, with or without a co-occurring substance use disorder, in reestablishing the knowledge and skills necessary to live independently.	Residential Level II Family Type (TFC) and Rapid Response Intensive In-Home Services (IIHS)	Target population includes members ages 16-24 are eligible for this service when there is a mental health diagnosis (as defined by the DSM-5, or any subsequent editions of this reference manual), must demonstrate a deficit in at least two Instrumental Activity of Daily Living (IADL)	H2022 U5

Attachment L. 7. Second Revised and Restated Approved Trillium Health Resources In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Behavioral Health Crisis Assessment and Intervention (BH-CAI)	A designated service that is designed to provide triage, crisis risk assessment, evaluation, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital Emergency Department.	Emergency Departments	Target population includes members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.	T2016 U5 or T2016 U6
Family Centered Treatment (FCT)	Family Centered Treatment is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals' effective practice.	Intensive In-Home Services (IIHS) Psychiatric Residential Treatment Facility (PRTF)	Target Population include a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity.	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4
High Fidelity Wrap-around (HFW)	High Fidelity Wraparound (HFW) is an intensive, teambased, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), who	Level II Group Setting & Program Level II Family Setting & Program	Target Population includes children, youth, and young adults with Serious Emotional Disturbance (SED) and have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and/or substance use problems.	H0032 - U5

	are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events.			
Family Navigator	Family Navigators can assist members and families to navigate these challenging times and to understand the changes in systems through lived experience. NC already offers this for adults who experience Mental Health and Substance use disorders using a Peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience IDD or TBI.	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Targeted Population includes Member diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems.	T2041 U5

Attachment L. 7. First Revised and Restated Approved Vaya Health In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members ages 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD.	Inpatient hospitalization Facility Based Crisis	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160
Outpatient Plus	Outpatient Plus ("OPT Plus") is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals of any age with complex clinical needs that basic outpatient therapy cannot adequately address.	Intensive In-Home Community Support Team	Target Population includes member has a mental health or SUD diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material); Member does not have service restrictions due to their NC Medicaid program eligibility category that would make them ineligible for this service.	H2021 U5
Critical Time Intervention	Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults ages 18 years and older with mental illness who are going through critical	Community Support Assertive Community Treatment Team Emergency Department visits Inpatient Psychiatric Admission	Target Population includes individuals discharge from psychiatric inpatient settings, release from correctional settings, transition out of foster care settings into adult	H0032 U5 HK

	transitions, and who have functional impairments which preclude them from managing their transitional need adequately. For this definition, CTI defines a critical transition as occurring within no more than 45 days from the start of service.		services, transition from homelessness in housing	
Behavioral Health Crisis Risk Assessment and Intervention (BHCAI)	A designated service that is designed to provide triage, crisis risk assessment, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital emergency department (ED). Individuals receiving this service have primary behavioral health needs and an urgency determination of urgent or emergent. Individuals receiving this service will be evaluated, stabilized, and/or referred to the most appropriate level of care.	Emergency Department Inpatient Hospital	Targeted Population includes	T2016 U5 or T2016 U6
Family Centered Treatment	Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services.	Residential Level II Program Type Residential Level III (1-4 beds)	Target Population includes Children and adolescents (ages 3-21) who have an MH/SUD diagnosis (some with co-occurring IDD) and are at risk of out of home placement or have previously been unsuccessful in residential treatment, or currently in residential treatment where discharge has been delayed due to identified need for family systems treatment.	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4

Residential Services – Complex Needs	This short-term residential treatment service focuses on members with primary diagnoses of intellectual/developmental disabilities (I/DD) with co-occurring mental health (MH) diagnoses or significant behavioral challenges. The members being served would benefit most from a multi-disciplinary approach with staff that are trained to treat I/DD, MH, and severe behaviors.	Psychiatric Residential Treatment Facility (PRTF) Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Target Population includes children and adults with dual diagnoses (I/DD and MH) who have high-level behavioral needs, have experienced multiple placements, and have difficulty functioning in community settings	H0018 HA
Rapid Care Services	Rapid Care Services allow time for extended assessment, which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period of time to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member. This includes observation in a secure, medically staffed and psychiatrically monitored setting as an alternative to the community hospital/ emergency department (ED).	Emergency Department Inpatient Hospital	Targeted Population includes mental health and/or substance use disorder(s), the member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation.	S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g.,	Residential Level II	Target Population includes youth with a mental health or substance use disorder diagnosis, youth requires coordination between two or more service agencies, including medical or non-medical providers; and youth has current or past history	H0032U5

	mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in a Psychiatric Residential Treatment Facility (PRTF) or other institutional settings, or are aging out of Department of Social Services (DSS) care.		within the last six months of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior	
In-Home Therapy Services	In-Home Therapy Services (IHTS) consist of evidence-based therapy services and coordination of care interventions provided in the home for individuals with complex clinical needs that outpatient therapy alone cannot adequately address in a time-limited fashion.	Intensive In-Home	Target Population includes a mental health (MH) and/or substance use (SU) diagnosis, symptoms and behaviors at home, school, or in other community settings, due to the member's MH and/or SU disorder, are moderate to severe in nature and require intensive, coordinated clinical interventions; evidence of problems in at least two major life domains that are significantly affecting the member's behavioral health needs	H2022 HE U5 H2022 TS U5
Enhanced Crisis Response (ECR)	Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth in the emergency department (ED) or in a non-therapeutic home who are at risk of admission to the ED, the practitioner will respond as soon as possible but	Emergency Department Inpatient Hospitalization	Target Population includes members ages 3-21 with mental health (MH) diagnoses, co-occurring MH and intellectual/ developmental disability (I/DD) diagnoses, and/or co-occurring MH and substance use disorder (SUD) diagnoses, OR potential diagnoses of the above based on current symptoms/behavioral health needs.	H2011 U5 U1 weekly unit

	no longer than two hours from receipt of the referral. For other referrals, response will be on the same day or by the end of the following day.			
Child- Focused Assertive Community Treatment	Child-Focused Assertive Community Treatment (Child ACT) is a team-based, multidisciplinary approach to serve children in their residential setting. This includes homes, kinship placements, and Department of Social Services (DSS) foster homes, or the service may begin during transition from a therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED).	Psychiatric Residential Treatment Facility (PRTF)	Target Population includes at risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment.	H0040 U5 HA
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses in reestablishing the knowledge and skills necessary to live independently.	Level II Family Type, Therapeutic Foster Care Residential Level II Program Type Residential Level III	Target Population includes members who are leaving the foster care or juvenile justice systems or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood.	H2022 U5
Assertive Community Treatment Step Down (ACT SD)	ACT SD service supports beneficiaries whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately addressed with Outpatient Therapy alone. ACT SD is a community based, person-centered and recovery focused service designed to assist the beneficiary in maintaining stable	Assertive Community Treatment (ACT)	Target Population includes beneficiaries with severe and persistent mental illness (SPMI) who have been participating in ACT services for at least six months	H0040 U5

	functioning and wellness while providing support for continued recovery.			

Section VI. First Revised and Restated Attachment M. Addendum for Division of State Operated Healthcare Facilities

1. Background

The Division of State Operated Healthcare Facilities (DSOHF) operates state-owned healthcare facilities that treat adults and children with mental illness, SUDs and I/DDs.[10] DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework. The PIHP shall execute a single standardized contract with DSOHF for all levels and types of services provided or offered by the state-owned facilities operated by DSOHF, using a contract template developed by the Department that covers all facilities and encompasses the required regulations.

2. Scope

The provisions of this Addendum address the requirements related to admissions, authorization of services, event reporting, grievances and appeals pertaining to services provided by DSOHF facilities that must be included and reflected in the contract between the PIHP and DSOHF facilities.

3. Admissions

When admitting a member to a DSOHF facility, the PIHP must comply with applicable laws, program requirements, and applicable policies and protocols established by the Department for the facility as set forth below:

a. Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATCs):
   i. The PIHP or PIHP designated community provider (e.g., BH community provider or hospital/emergency department) shall complete a referral via the Department's bed registry electronic referral system or submit a Regional Referral Form to DSOHF until electronic referral is available. The Regional Referral Form is located on the Department's website.
   ii. The PIHP must review the admission based on review of the information provided in the Regional Referral Form or the Department's bed registry electronic referral system.
   iii. In cases where the Member presents directly to a psychiatric hospital or ADATC for admission, the PIHP shall comply with applicable provisions of EMTALA and other applicable laws (Section 1867(a) of the Social Security Act) related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.
   iv. The PIHP shall ensure that a PIHP-employed utilization management staff member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission;
   v. For members subject to involuntary commitment proceedings, the PIHP must provide information or a representative who can assist the district court in determining if the member requires continued services. If the PIHP elects to send a representative to appear in court, the representative may be a community provider or other designated provider (e.g., contracted BH provider, hospital or emergency department representative) as determined by the PIHP.

[10] DSOHF also serves individuals with neuro-medical needs in specialized treatment centers that are carved out of Medicaid Managed Care and therefore not included in the PIHP contract.

vi. Prior to referral or authorization of any member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the PIHP must verify that the referral is in accordance with the requirements of N.C.G.S. 122C-261 and any other applicable North Carolina law governing the admission of members with intellectual disabilities to a State psychiatric hospital.
vii. For members who have multiple disorders and medical fragility or have multiple disorders and deafness, the PIHP shall be designated by the Department to determine whether members have a high level of disability which indicates that alternative care is inappropriate, consistent with N.C.G.S. § 122C-261(e)(4).
viii. In determining whether members with known or reasonably believed I/DD are eligible for referral and/or authorization for admission to a State psychiatric hospital, the PIHP must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose to determine that any less restrictive and less costly options in the community have been exhausted.

b. State Developmental Centers:
   i. The PIHP must exhaust all options for community care and supports before it refers a Member to a State Developmental Center.
   ii. When a PIHP refers a Member to a State Developmental Center, the PIHP must submit an application packet, inclusive of a letter of endorsement, to the State Developmental Center Admission/Discharge Coordinator;
   iii. The PIHP must comply with the DSOHF admission criteria and protocols; and
   iv. The PIHP must ensure timely execution of the Memorandum of Agreement (MOA)[12] with the Member's guardian regarding the Member's discharge plan.

4. Authorization

The PIHP must authorize benefits provided by DSOHF facilities in accordance with the relevant Medicaid clinical coverage policies as detailed in *Section IV.F.1 Behavioral Health and I/DD Benefits Package*, respectively, as well as the specific requirements listed below.

a. General Requirements for State Psychiatric Hospitals and ADATCs:
   i. Emergency Services:
      A. The PIHP must cover emergency medical services provided by the DSOHF facility without regard to prior authorization.
      B. The PIHP cannot refuse to cover emergency services based upon the DSOHF facility failing to notify the member's PIHP of the individual's screening and treatment following presentation for emergency services.
      C. Reserved.
      D. Reserved.
   ii. Inpatient Services:
      A. The PIHP must issue a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the request for services, provided that the deadline may be extended for one additional business day if: (i) the individual or DSOHF facility requests the extension; and (ii) the PIHP justifies to

[12] The MOA is a formal agreement made between the State Developmental Center, legally responsible person/guardian, and the PIHP identifying the responsibilities of all parties in supporting the individual to return to their home or community setting within the identified length of admission as specified in the MOA.

the DSOHF facility a need for additional information and how the extension is in the Member's interest.

B. The PIHP must authorize an admission authorization for a minimum of ten (10) days for inpatient psychiatric services and for a minimum of seven (7) days for ADATC services.

C. Following initial admission authorization, the PIHP must review and evaluate for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every seven (7) days for ADATC services.

D. To request re-authorization, the psychiatric hospital or ADATC shall submit the electronic re-authorization for continued stay request to the PIHP prior to the expiration of the prior authorization no later than the last covered day of the existing authorization, or the previous business day if the last covered day occurs on a weekend or holiday.

E. The PIHP must issue an authorization decision and notify the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the re-authorization request.

b. Requirements for Assessment and Stabilization

i. The PIHP shall be responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of members who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).

ii. The PIHP must identify an appropriate discharge plan for all such members beginning at admission.

c. Requirements for State Developmental Centers:

i. Initial authorization:

A. Prior to admission to a State Developmental Center, the PIHP shall complete the ICF-IID level of care determination form (Level of Care Form) including obtaining the physician signature and send a copy to the facility's reimbursement office to complete the authorization to bill Medicaid.

B. If authorization is not received from the PIHP by the time of admission to a State Developmental Center, the PIHP shall promptly provide retrospective authorization after:

1. The State Developmental Center sends the EAR to the PIHP; and
2. The State Developmental Center receives the Level of Care Form from the PIHP, completes it and submits it to the PIHP

ii. Re-authorization:

A. To reauthorize services in a State Developmental Center, the facility must send a completed Level of Care Form, Person Centered Plan (PCP) if it has been updated since the previous authorization, and psychological evaluation to the PIHP prior to the expiration of the initial authorization.

B. Upon receipt of the required documentation, the PIHP must approve or deny the request in accordance with the standard timeframes for service authorization requests. Authorization shall be for at least 180 days from the date of the physician signature on the Level of Care Form. The PIHP must review the Utilization Review Level of Care form every six months even if the authorization is in excess of 180 days.

C. Reserved.
    1. Reserved.

iii. Facility-based respite services for members enrolled in the Innovations Waiver:
    A. The PIHP shall issue prior authorization for Respite Facility Based services provided at a State Developmental Center prior to a member's admission.

5. Member Grievances

a. The DSOHF facility and the Department will manage and resolve all member clinical concerns, or grievances related to the clinical services provided, in accordance with applicable North Carolina law governing Department facility grievance procedures and reports (including but not limited to, 10A NCAC 28B.0203 through .0205) and other applicable laws, in accordance with grievance procedures established by the Department.
b. The PIHP must agree that DSOHF facilities shall refer any unresolved patient grievances to the Secretary of the Department. The DSOHF facility will have in place a written policy for a complaint and grievance Process and procedures for review and disposition of patient Grievances, which shall include making available to patients the PIHP Hotline number for reporting any grievances.)

6. Event Reporting and Abuse/Neglect/Exploitation.

a. The PIHP must agree that the Department and the North Carolina Quality Center Patient Safety Organization (PSO) oversee and manage any abuse, neglect, exploitation allegations and incidents pertaining to members receiving services provided by DSOHF (collectively, individual safety events/allegations) in accordance with the federal Patient Safety and Quality Improvement Act of 2005.
b. The PIHP must agree to maintain the confidential and privileged framework for management of individual safety events/allegations with the PSO.
c. The DSOHF facility will cooperate with the PIHP's written request for information regarding any individual safety events/allegations involving members to the extent required by applicable laws and permitted under the Patient Safety Act and Rules, including but not limited to providing the PIHP with any RL6 incident report logs that are not subject to PSO privilege and confidentiality, within three (3) Business Days after receipt of the PIHP's request.
d. The PIHP shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the facility. The PIHP shall provide the DSOHF a written summary of its finding within thirty (30) Calendar Days. (Note: During such an investigation, if any issues are cited as out of compliance with applicable laws, the DSOHF facility may be required to document and implement a plan of correction.)

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

Table 1: Liquidated Damages for Compliance Issues

Section VI. Fourth Revised and Restated Attachment N: Table 1: Liquidated Damages (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$1,250 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section III.B.15. Disclosure of Conflicts of Interests* and *Section IV.A.6. Staffing and Facilities.*	$2,500 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.B.16. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition.*	$250 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.B.17. Disclosure of Ownership Interest*.	$625 per contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in *Section III.B.46 Subcontractors.*	Up to $12,500 per occurrence
B. Members		
1.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section IV.E.4. Marketing.*	$1,250 per occurrence
2.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section IV.E.1 Eligibility and Enrollment for PIHP.s*	$125 per occurrence per Member
3.	Reserved.	
4.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section IV.E.3 Member Engagement.*	Up to $12,500 per occurrence
5.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section IV.E.6. Member Grievances and Appeals.*	$125 per occurrence

Section VI. Fourth Revised and Restated Attachment N: Table 1: Liquidated Damages (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
6.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$1,250 per occurrence
7.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section IV.E.6. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by Department for the timeframe specified by Department. AND $125 per Calendar Day for each day PIHP fails to provide continuation or restoration as required by Department.
8.	Failure to attend mediations and hearings as scheduled as specified in *Section IV.E.6. Member Grievances and Appeals.*	$250 for each mediation or hearing that PIHP fails to attend as required
9.	Failure to comply with Transition of Care requirements as specified *Section IV.G.3. Care Coordination and Care Transitions for all Members.*	$25 per Calendar Day, per Member AND The value of the services PIHP failed to cover during the applicable transition of care period, as determined by Department.
10.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the PIHP in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the PIHP in connection with the internal plan appeal within the requirements in *Section III.D. 37 Response to State Inquiries and Request for Information*.	$125 per occurrence.
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	$1,250 per occurrence per Member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section IV.F.1. Behavioral Health and I/DD Benefits Package.*	$1,250 per standard authorization request $1,875 per expedited authorization request

Section VI. Fourth Revised and Restated Attachment N: Table 1: Liquidated Damages (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
3.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section IV.H.1. Provider Network.*	$250 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section IV.F.1. Third Revised and Restated Table 6: Required Clinical Coverage Policies.*	$625 per occurrence
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination Policy as required by *Section IV.G.2. Tailored Care Management.*	$62.50 per Calendar Day
2.	Failure to develop a care management comprehensive assessment, Care Plan, or Individual Support Plan for a member that includes all required elements as described in *Section IV.G.2. Tailored Care Management* (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	$125 per deficient/missing care management comprehensive assessment or plan
3.	Reserved.	[redacted]
4.	Reserved.	
5.	Failure to comply with minimum care coordination requirements for members with a BH transitional care need as described in *Section IV.G. Care Management and Care Coordination.*	$62.50 per occurrence per Member
6.	Failure to comply with federal conflict-free case management requirements for Members enrolled in the Innovations Waiver.	$125 per occurrence per Member
7.	Failure to complete initial meetings for Members in foster care/adoption assistance and former foster youth within seven (7) Calendar Days of PIHP enrollment, as described in *Section IV.G. Care Management and Care Coordination.*	$500 per occurrence
8.	Failure to schedule and attend meetings with County Child Welfare Workers for Members involved in the child welfare system, as described in *Section IV.G Care Management and Care Coordination.*	$500 per occurrence
9.	Failure to meet annual requirements established by the Department for the percentage of members actively assigned to a Provider-based Tailored Care Management entity as set forth in *Section IV.G.2.(b)(ii) Provider-based Tailored Care Management*. (Effective January 1, 2024)	Up to $25,000 per percentage below the requirement each calendar year
E. Providers		
1.	Failure to update online and printed provider directory with accurate provider information as required by *Section IV.H.2. Provider Network Management.*	$250 per confirmed incident

Section VI. Fourth Revised and Restated Attachment N: Table 1: Liquidated Damages (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure to report notice of provider termination from participation in the PIHP's provider network (includes terminations initiated by the provider or by the PIHP) to the Department or to the affected Members within the timeframes required by *Section IV.H.2. Provider Network Management.*	$25 per Calendar Day per Member for failure to timely notify the affected member or Department
3.	Reserved.	
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section IV.H.1. Provider Network.*	$1,250 per Calendar Day
5.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in *Section IV.H.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$625 per month for failure to meet any of the listed standards, either individually or in combination
6.	Failure to timely submit a PIHP Network Data File that meets the Department's specifications.	$62.50 per Calendar Day
7.	Reserved.	
8.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section IV.L. Technical Specifications*.	$250 per occurrence
9.	Failure to remove providers that are not actively enrolled in NC Medicaid within the PIHP Network File within one (1) Business Day as specified in *Section IV.H.2. Provider Network Management*.	$25 per provider per Business Day
F. Quality and Value		
1.	Failure to submit all required quality measures including audited HEDIS results within the timeframes specified in *Section IV.I.1. Quality Management and Quality Improvement.*	$1,250 per Calendar Day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section IV.I.1. Quality Management and Quality Improvement.*	$250 per Calendar Day
3.	Failure to timely submit QAPI to the Department as described in *Section IV.I.1. Quality Management and Quality Improvement.*	$250 per Calendar Day
G. Claims and Encounter Management		
1.	Failure to timely submit monthly encounter data set certification.	$250 per Calendar Day
H. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day

Section VI. Fourth Revised and Restated Attachment N: Table 1: Liquidated Damages (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$250 per calendar day
3.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section IV.K.2. Medical Loss Ratio* and *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day
4.	Failure to timely and accurately submit financial reports in accordance with *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$250 per Calendar Day
I. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section IV.C. Compliance.*	$1,250 per Calendar Day that Department determines PIHP is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section IV.C. Compliance and Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$250 per Calendar Day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section IV.C.4. Third Party Liability (TPL) and Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$62.50 per Calendar Day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$625 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to PIHP's own conduct, a provider, or a member.	$62.50 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section IV.C. Compliance and Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day
J. Technical Specifications		
1.	Failure by the PIHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$125 per Member per occurrence

Section VI. Fourth Revised and Restated Attachment N: Table 1: Liquidated Damages (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure by the PIHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$125 per occurrence
3.	Failure by the PIHP to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	$125 per Member per occurrence, not to exceed $2,500,000
K. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$125 per Calendar Day
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$250 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$125 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above.	$ 5,000 per occurrence per plan or program
5.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	$125 per Calendar Day for each day the CAP is late, or for each day PIHP fails to comply with an approved CAP
6.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$125 per occurrence.

Table 2: Metrics, SLAs and Liquidated Damages

Section VI. Fourth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (October 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The PIHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PIHP to its system to trigger enrollment and disenrollment processes.	Daily	$250 per twenty-four (24) hour period Note: Effective one (1) month prior to Medicaid Direct PIHP launch.
2.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the PIHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	The PIHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the PIHP within the required timeframe divided by the total number of new Members enrolled in the PIHP during the measurement period.	Monthly	98.99% - 95%:$1,250 per month 94.99% - 80%: $1,875 per month 79.99% or less: $2,500 per month
3.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the PIHP utilizes separate mailings to send components of the Welcome Packet*	The PIHP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the PIHP within the required timeframe divided by the total number of new Members enrolled in the PIHP during the measurement period.	Monthly	98.99% - 95%: $1,250 per month 94.99% - 80%: $1,875 per month 79.99% or less: $2,500 per month
4.	Provider Welcome Packet Timeliness	The PIHP shall meet or exceed ninety-eight percent (98%) of	The number of Provider Welcome Packet sent by the	Quarterly	97.99% - 95%: $1,250 per quarter

Section VI. Fourth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (October 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		Provider Welcome Packets mailed within the timeframes specified in *Section IV.H.3.b.iv Provider Relations and Engagement.*	PIHP within the required timeframe divided by the total number of new providers who have executed a contract with the PIHP during the measurement period.		94.99% - 80%: $1,875 per quarter 79.99% or less: $2,500 per quarter
B. Member Grievances and Appeals					
1.	Member Appeals Resolution -Standard	The PIHP shall resolve at least ninety-eight percent (98%) of PIHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PIHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	96.00%-97.99%= $1,250 per month 95.99% or less= $2,500 per month
2.	Member Appeals Resolution -Expedited	The PIHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PIHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	99.01% - 99.49% = $1,875 per month 99.00% or less = $2,500 per month

Section VI. Fourth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (October 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Member Grievance Resolution	The PIHP shall resolve at least ninety-eight percent (98%) of member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PIHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	96.00% - 97.99% = $875 per month 95.99% or less = $1,250 per month
C. Care Management					
1.	Contracting with AMH+ and CMAs	The PIHP shall contract with one hundred percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in *Section IV.G.2 Tailored Care Management.*	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the PIHP divided by the total number of certified and willing AMH+ practices and CMAs.	Monthly	$12,500 per month
D. Encounters					
1.	Encounter Data Timeliness	The PIHP shall submit ninety-eight percent (98%) of encounters within thirty (30) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$12.50 per encounter per Calendar Day

Section VI. Fourth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (October 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
2.	Encounter Data Accuracy	The PIHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$6,250 per month
3.	Encounter Data Reconciliation-	The encounters submitted by the PIHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PIHP.	Monthly	$2,500 per month

Section VI. Fourth Revised and Restated Attachment N. Table 3: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot) (October 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
1	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements.	$125 per Calendar Day that the Department determines the PIHP is not in compliance
2	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes.	$125 per Calendar Day
3	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes.	$125 per Calendar Day per HSO
4	Failure to comply with the following provisions enumerated in *Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* of to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs: • Ensure that PIHP workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data; • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials; and • Ensure that Care Managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment.	$125 per occurrence