Amendment Number 12 (13)

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 subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits ("Division"), and Entity Name ("Contractor" or "PIHP"), 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:

I. Modify requirements in *Section II. Definitions and Abbreviations*.

II. Modify requirements in *Section IV. Scope of Services*; and

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

The Parties agree as follows:

I. Modifications to Section II. Definitions and Abbreviations

***Section IV. A. Definitions, 45. Close Network* is revised and restated in its entirety as follows:**

45. **Closed Network:** Has the same meaning as "closed network" defined in N.C. Gen. Stat. § 108D-26(b).

II. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

a. *Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, i.* is revised and restated in its entirety as follows:

i. The PIHP shall develop a single utilization management (UM) program applicable to covered services under both the PIHP and BH I/DD Tailored Plan Contract services that is based on nationally-recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in the required NC Medicaid clinical coverage policies set forth in *Section IV.F.1.e.vii. and the Third Revised and Restated Table 6: Required Clinical Coverage Policies* of the Contract, subject to the following:

1. The PIHP shall incorporate NC Medicaid Direct clinical coverage policies into its UM Program in accordance with the *Section IV.F.1. Third Revised and Restated Table 6: Required Clinical Coverage Policies* of this Contract.
2. The PIHP shall submit to the Department through the Prepaid Health Plan Data Utility (PCDU) for review and approval an updated parity analysis workbook that documents the policies and procedures, as written and in operation, and processes, evidentiary standards, strategies, or other factors used by the PIHP in applying non-quantitative UM limits at the following times:
    a. Department Initiated:
        i. When covered benefits are to be added to, modified by, or removed from the Contract, the Department's Contract Administrators shall notify the PIHP's Contract Administrators in writing of the revisions to be incorporated via a Contract Amendment;

ii. The PIHP shall submit to the Department information needed for the Department to conduct a parity analysis by submitting an updated parity analysis workbook no later than thirty (30) Calendar Days after the Department notifies the PIHP of covered benefits intended to be added to, modified by, or removed from the Contract;

iii. The Department shall allow the PIHP sixty (60) Calendar Days after receipt of the Department's response to the updated parity analysis workbook, unless an earlier timeframe is mandated by CMS, to implement any revisions requested by the Department to be incorporated;

b. PIHP Initiated: The PIHP shall submit to the Department an updated parity analysis workbook at least forty-five (45) Calendar Days before the PIHP adds or changes a non-quantitative UM limit to one or more covered benefit(s).

c. Irrespective of whether the updated parity analysis workbook is submitted following a Department-initiated or PIHP-initiated request, the Department shall review and notify the PIHP of its approval or request for more information within thirty (30) Calendar Days of receipt of the PIHP's updated parity analysis workbook.

3. At least forty-five (45) Calendar Days before the PIHP adds or changes a quantitative limit applied to covered benefits, the PIHP shall submit to the Department an updated parity analysis workbook to allow the Department to determine whether the proposed limit(s) is/are parity compliant. The PIHP may submit one parity analysis workbook inclusive of both the PIHP and BH I/DD Tailored Plan program.
4. Notwithstanding *Section IV.F.1.e.vii.1*. of the Contract, if the Department determines that one or more UM quantitative or non-quantitative limits applied by the PIHP cause the North Carolina Medicaid Direct program to be noncompliant with applicable mental health parity requirements, the PIHP shall remove the UM limit(s) identified by the Department as being noncompliant from its PIHP and BH I/DD Tailored Plan UM Program within sixty (60) Calendar Days of the Department giving the PIHP Notice of the non-compliant limit(s) to be removed.
5. The PIHP shall ensure the UM program aligns with the parameters laid out in *Section IV.A.3. Readiness Review Requirements*, to the degree a Subcontractor relationship applies.

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

1. Notwithstanding the foregoing provision at *Section IV.F.1.e.vii.* of the Contract or any provision in the NC Medicaid Direct clinical coverage policies listed in *Section IV.F.1. Third Revised and Restated Table 6: Required Clinical Coverage Policies,* the PIHP may incorporate one or more additional and/or amended UM quantitative or non-quantitative limit(s) not appearing in NC Medicaid Direct clinical coverage policies into its UM Program, subject to all of the following conditions:
   a. The additional and/or amended UM limit(s) not appearing in NC Medicaid Direct clinical coverage policies that the PIHP proposes to apply to one or more covered benefit(s) under the BH I/DD Tailored Plan Contract shall apply to the same covered benefit(s) offered under this Contract by the PIHP;
   b. At least forty-five (45) Calendar Days prior to implementing one or more additional and/or amended UM limit(s), the PIHP shall submit to the Department for review and approval the proposed additional and/or amended UM limit(s) along with an updated parity analysis workbook in the manner described in *Section IV.F.1.i.2.* or *3.*, as applicable, of this Contract; and
   c. The PIHP receives Department approval to incorporate one or more of the proposed additional or amended UM limit(s) into the PIHP's UM Program.
2. The PIHP shall post to its public-facing webpage and shall notify its Providers via posting on its provider-facing webpage, Provider portal, or Provider bulletin of the additional and/or amended UM

limit(s) that have been approved by the Department to be added to the PIHP's UM Program at least thirty (30) Calendar Days before the approved UM limit(s) are effective.

c. *Section IV. H. Providers, 1. Provider Network, e. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207), i.,2.,iv.* is revised and restated in its entirety as follows:

iv. Within thirty (30) Calendar Days of a Significant Change, including merger, opening of Contractor's Network as to one or more service(s) in accordance with *Section IV.H.2.a.* of the Contract, or county disengagement.

d. *Section IV. H. Providers, 2. Provider Network Management, a.* is revised and restated in its entirety as follows:

a. The PIHP shall manage its Network to meet availability, accessibility, and quality goals and requirements.
   i. In developing its network for BH and I/DD services, the PIHP shall ensure network adequacy and has the authority to maintain a closed network for services as set forth in N.C.G.S. § 108D-26 and this Contract.
   ii. The PIHP shall accept all providers of services covered under this Contract who appear on the Provider Enrollment File (PEF) and accept network rates, except as to services specified by the Department in *Section IV.H. Table 2: Services Subject to Closed Network Authority under N.C.G.S. § 108D-26* of this Contract. If PIHP is made aware of a provider on the PEF that is on an Exclusion List, the PIHP shall notify OCPI and may refuse to contract with the provider or terminate the provider in accordance with *Section IV. C. 2.c.(i)*.
      1. The Department shall give Contractor Notice of any proposed changes to, and a copy of, intended amendments to the list of services for which the PIHP shall maintain a closed network ("Closed Network List") set forth in *Section IV. H. Table 2: Services Subject to Closed Network Authority under N.C.G.S. § 108D-26* of this Contract at least sixty (60) Calendar Days before the intended effective date of changes to the Closed Network Services List memorialized in an amendment.
         a. Within fourteen (14) Calendar Days of receiving Notice of proposed changes to the Closed Network Services List set forth in *Section IV.H. Table 2: Services Subject to Closed Network Authority under N.C.G.S. § 108D-26* of this Contract, the PIHP shall submit any feedback regarding changes to the Closed Network Services List to the Department for consideration.
      2. Pursuant to N.C. Gen. Stat. § 108D-26(c), the PIHP shall maintain a closed network as to the services appearing in *Section IV. H. Table 2: Services Subject to Closed Network Authority under N.C.G.S. § 108D-26* of this Contract:

Section IV. H. Table 2: Services Subject to Closed Network Authority under N.C.G.S. § 108D-26
• Assertive Community Treatment (ACT); • Multi-Systemic Therapy (MST); • Community Support Team (CST); • Intensive In-Home Services; • Child and Adolescent Day Treatment; • SUD Residential Treatment Services (ASAM 3.1, 3.3, 3.5, 3.7); • Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IDD); • All 1915(c) Home and Community Based Innovations Waiver services: • All 1915(c) Home and Community Based TBI Waiver services

- All 1915(i) Home and Community Based Waiver services
- All 1915(b)(3) Waiver Services (Individual Support, Intensive Recovery Support, In-Home Skill Building, One-Time Transitional Costs, Respite, Supported Employment, and Transitional Living Skills).

iii. The Department shall make a determination as to whether each approved in lieu of service (ILOS) offered by the PIHP shall be offered under a closed or open Network.

a. To facilitate the Department's determination on whether an existing ILOS may be offered via an open or closed provider Network, the PIHP shall submit to the Department by no later than MONTH DD, 2025 (Date will be enter as 45 days from the Department's execution date):

i. The PIHP's parity-compliant recommendation for whether the existing ILOS shall be offered under a closed or open Network; and

ii. Rationale to support the PIHP's parity-compliant recommendation where the PIHP seeks approval to offer an ILOS under a Closed Network.

iii. Within forty-five (45) Calendar Days of receiving the PIHP's parity-compliant recommendation and rationale required under this subsection, the Department shall give the PIHP Notice of whether the existing ILOS shall be offered via a closed or open Network.

b. To facilitate the Department's determination on whether a new or modified existing ILOS may be offered via an open or closed provider Network, the PIHP shall submit to the Department at the time of requesting approval to offer a new or change an existing ILOS:

i. The PIHP's parity-compliant recommendation for whether the new or changed ILOS shall be offered under a closed or open Network; and

ii. Rationale to support the PIHP's parity-compliant recommendation where the PIHP seeks approval to offer the ILOS under a Closed Network.

iii. The Department shall include as part of the PIHP's ILOS approval notification the Department's determination on whether the approved ILOS shall be offered via a closed or open Network.

iv. Notwithstanding *Section IV.H.2.a.ii.* or any other provision in this Contract, nothing shall preclude the PIHP from taking adverse action, including, but not limited to, termination of a Provider's contract or ability to deliver services under a Provider's contract with PIHP in accordance with the PIHP's contract with a Provider.

v. The PIHP shall have a provider monitoring program to ensure providers are meeting Member needs and program requirements.

f. ***Section IV. H. Providers, 4. Provider Payments, k. Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services), iv.*** **is revised and restated in its entirety as follows:**

iv. Unless an agreement has been negotiated, the PIHP shall reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee for Service rate for: BH,I/DD, and TBI services when the PIHP has not made a "good faith" effort as defined in the PIHP's Good Faith Provider Contracting Policy or the PIHP has exercised its authority to maintain a closed network for services as set forth in N.C. Gen. Stat. § 108D-26.

III. Modifications to Section VI. Contract Attachments

Section VI. Third 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. Fourth Revised and Restated Attachment L. Policies, 3. Uniform Credentialing and Re-credentialing Policy for Medicaid*** **and is attached to this Amendment.**

VI. Effective Date

This Amendment is effective April 1, 2025, 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. Attachment L. Policies. 3. Fourth 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 PIHP services as set forth in N.C.G.S. § 108D-26 and/or this Contract. 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 that PIHP Network Providers enrolled with NC Medicaid 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 policies 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 or the NC Exclusions List;
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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