Amendment Number 13 (14)

Contract #30-2022-007-DHB-#

Medicaid Direct Prepaid Inpatient Health Plan Contract

THIS Amendment to Contract #30-2022-007-DHB-# (Contract), as subsequently amended is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and PIHP Name (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 in the following Sections:

- **I.** Section II. Definitions and Abbreviations;
- **II.** Section III. Contract Term, General Terms and Conditions, Protections, and Attachments;
- **III.** Section IV. Scope of Services; and
- **IV.** Section VI. Attachments.

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, 203. RN/OT Evaluator Team:*** **is revised and restated in its entirety as follows:**

203. **RN/OT Evaluator Team:** The PIHP's Registered Nurses and Occupational Therapists, or Certified Occupational Therapist Assistants providing physical health and functional assessments for individuals and transition planning assistance to individuals in TCL with complex medical conditions and/or significant functional deficits.

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

228. **System Security Plan (SSP)**: Serves as an overview of the security requirements for the system and its components by describing the security controls in place, or planned, for meetings those requirements, the rationale for security categorization, how individual controls are implemented within specific environments, and situational system usage restrictions. Additional information regarding the System Security Plan is available at the following link, accurate as of April 25, 2025: https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-securityhttps://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security. The term Security Compliance Plan (SCP) may be used interchangeably with System Security Plan (SSP).

c. ***Section II. B. Acronyms*****. The following acronyms are revised in their entirety as follows:**

23. Reserved
110. Reserved

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

251. ACH: Adult Care Home
252. IR/TCL: In-Reach Transitions to Community Living
253. QMIP: Quality Management and Improvement Plan

254. UNC: University of North Carolina

II. <u>Modifications to Section III. Contract Term, General Terms and Conditions, Protections, and Attachments</u>

Specific subsections are modified as stated herein.

a. *Section III. B. General Terms and Conditions, 29. <u>MEDIA CONTACT APPROVAL AND DISCLOSURE:</u>* is revised and restated in its entirety as follows:

29. <u>MEDIA CONTACT APPROVAL AND DISCLOSURE:</u>

a. Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. In the event the Contractor is contacted by the media for information related to the terms of this Contract, the Contractor shall contact the Department as soon as practical. Contractor must submit any proposed media release regarding the terms of this Contract to the Department for review and approval at least seven (7) State Business Days in advance of intended disclosure, to the extent practical. The Department may, to the extent reasonable and lawful, timely object to its publication or require changes to the information intended for public release. The requirements of this Section shall not apply to any information the Contractor is required by law or by any court of competent jurisdiction to disclose.

b. Media Interviews: Contractor shall not agree to participate in a media request for an interview related to the terms of this Contract prior to obtaining prior approval from the Department which approval shall not be unreasonably withheld. Upon receipt of a request for an interview, Contractor shall provide the information outlined in the Health Plan Media Interview Request Instructions for Health Plans to the Department for review.

b. *Section III. B. General Terms and Conditions, 33. <u>PARTICIPATION IN CATCHMENT AREA SERVICE CONTINUITY:</u>* is revised and restated in its entirety as follows:

33. **<u>PARTICIPATION IN CATCHMENT AREA SERVICE CONTINUITY</u>**: In the event the Department terminates, suspends, or delays a PIHP Contract in another Catchment Area, the Contractor agrees, contingent upon appropriation of sufficient funding to Contractor from the Department to perform the additional work, to meaningfully participate with the Department, all other active PIHP Contractors, and any other entities as required by the Department in a collaborative process to identify solutions for ensuring service continuity in such Catchment Area. Solutions identified under the process may include, but are not limited to, expanding the Contractor's service area, leveraging the Contractor's network building capabilities, and Contractor support for other operational activities.

c. *Section III. B. General Terms and Conditions, 34. <u>PAYMENT AND REIMBURSEMENT:</u> a. PIHP Payments:* is revised to add the following:

v. Additional Directed Payments for Certain Providers.

d. *Section III. B. General Terms and Conditions, 34. <u>PAYMENT AND REIMBURSEMENT:</u> c. Tailored Care Management Payments:,* is revised to add the following:

i. If a PIHP is notified by an AMH+ practice, CMA, or the Department and/or independently identifies a TCM Member who was reassigned to the PIHP for TCM but should have remained assigned to the

AMH+ practice or CMA TCM Provider, the PIHP should follow the process outlined in *Section IV.G.2.f.xxii.* of this Contract. During the time period that one or more Member(s) systematically show as being assigned to the PIHP for receipt of TCM but should have been assigned to the AMH+/CMA TCM Provider, the PIHP shall make the Tailored Care Management payment to the AMH+/CMA to which the Member should have been assigned in accordance with *Sections III.B.34.c.* and *IV.H.4.i.* of this Contract.

e. *Section III. B. General Terms and Conditions, 34. PAYMENT AND REIMBURSEMENT:* is revised to add the following:

k. **Additional Directed Payments for Certain Providers:** The Department will make payments to the Contractor to support additional, utilization-based, directed payments to certain providers as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) and in accordance with *Section IV.H.4 Provider Payments.*

f. *Section III. B. General Terms and Conditions, 51. OUTSOURCING:* is struck from the Contract in its entirety to make a technical correction due to duplication of *Section III.D.32. OUTSOURCING*.

g. *Section III. C. Confidentially, Privacy and Security Protections, 5. Information Technology, a.-c.* is revised and restated in its entirety as follows:

a. Contractor shall comply with and adhere to all applicable federal and North Carolina laws, regulations, policies, and guidelines, including but not limited to HIPAA, CMS and State IT Security Policy and Standards; Department Privacy and Security Policies; and the most recent Information Security and Privacy guidance shared by CMS. State and Department policies may be revised periodically, with at last thirty (30) Calendar Days' notice to Contractor and Contractor shall comply with any revisions following the notice period as soon as practicable upon written notification of such revision(s). The State Security Manual is available at the following link, accurate as of April 25, 2025: https://policies.ncdhhs.gov/document/security-manual/.

b. Contractor's information technology systems shall meet all State and federal statutes, rules and regulations governing information technology (including but not limited to 26 U.S.C. 6103, SSA, IRS Publication 1075, and HIPAA) and the policies of the NC Department of Information Technology, including NIST 800-53, as outlined in the State's Information Security Manual which can be found at the following links, accurate as of April 25, 2025. *See e.g.,* https://it.nc.gov/statewide-information-security-policies; https://it.nc.gov/documents/statewide-information-security-manual and https://it.nc.gov/document/statewide-data-classification-and-handling-policy.

c. Enterprise Architecture Standards: The North Carolina Statewide Technical Architecture standards are located at the following link, accurate as of April 25, 2025: https://it.nc.gov/resources/statewide-it-procurement/vendor-engagement-resources. This provides a series of domain documents describing objectives, principles and best practices for the development, implementation and integration of business systems.

h. *Section III. C. Confidentially, Privacy and Security Protections, 5. Information Technology, f.* is revised and restated in its entirety as follows:

f. Patch Management: As soon as practicable upon receipt of written notification of the need to do so, the Contractor will apply patches based on State requirements on or to any Information Technology Systems or platforms that share information with (or interfaces with) the Department's Information Technology Systems or which may impact the delivery of services to the Department's members, provided that the patches do not disrupt Contractor operations. The State requirements are located at the following link, accurate as of April 25, 2025:

https://it.nc.gov/documents/statewide-information-security-manual. The Contractor will coordinate patching activity with the Department to be sure any dependent patching that needs to be implemented on Department Information Technology Systems or platforms is completed in the conjunction with Contractor patching. The requirement to apply the patch may come from the Contractor, the Department, or an external organization such as https://www.us-cert.gov/.

i. *Section III. E. Confidentiality, Privacy and Security Protections, 9. Security, a. State of NC Security Standards and DHHS Privacy and Security Standards, i.* is revised and restated in its entirety as follows:

i. Contractor shall comply with all security standards including those published in the State of North Carolina Statewide Information Security Manual, the Department PSO Standards, and any federal regulations and requirements (found at the following link, accurate as of April 25, 2025: https://policies.ncdhhs.gov/document/security-manual/. The State of North Carolina Statewide Information Security Manual is available at the following URL, accurate as of April 25, 2025: https://it.nc.gov/statewide-information-security-policies. The Department will work with the Contractor to validate compliance with the PSO standards.

j. *Section III. E. Confidentiality, Privacy and Security Protections, 9. Security, c. State of NC Data Classification and Handling* is revised and restated in its entirety as follows:

c. State of NC Data Classification and Handling
The State of North Carolina Data Classifications as published in the North Carolina Department of Information Technology Data Classification and Handling Policy guide and the related handling procedures will apply to all data held in Contractor's IT systems on behalf of the Department, and in the execution of this Contract. The guide is available at the following URL, accurate as of April 25, 2025: https://it.nc.gov/document/statewide-data-classification-and-handling-policy.

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), (viii)* is revised and restated in its entirety as follows:

viii. Managed Care Clinical Supplemental Guidance;

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

xxix. Direct Support Professional (DSP) Workforce Plan; and
xxx. Health Plan Media Interview Request Instructions for Health Plans.

c. *Section IV. A. Administration and Management, 1. Medicaid Program Administration, l., i.-ii.* is revised and restated in its entirety as follows:

i. Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable.
ii. End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting. The Department, if deemed necessary for the project execution, shall develop and provide an End-to-End test plan aligned with specific requirements for the program that includes all systems part of End-to-End testing. At a minimum, the End-to-End testing Plan shall include:
1. High level description of End-to-End Testing scope;

2. High level overall End-to-End Testing duration;
3. Applications or systems that are part of End-to-End testing; and
4. Integrations that are part of End-to-End testing.

d. *Section IV. B. Program Operations, 1. Service Lines, r. Behavioral Health Crisis Line:, iv.* is revised and restated in its entirety as follows:

iv. Must have warm transfer capabilities to crisis emergency service lines, including (but not necessarily limited to) 911, 988, (855)-PEERS NC peer warm line, and mobile crisis teams. In instances where there is immediate danger to self or others, the PIHP shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.

1. The BH I/DD Tailored Plan Behavioral Health Crisis must have warm transfer capabilities to the NC peer warm line (1- 855-PEERS NC).

e. *Section IV. B. Program Operations, 1. Service Lines, r. Behavioral Health Crisis Line:* is revised to add the following:

viii. Must have the capability to refer Members to appointments for the appropriate level of behavioral health services in accordance with the timeframes set forth in *Section VI. Fourth Revised and Restated Attachment E: PIHP Network Adequacy Standards, Table 3: Appointment Wait Time Standards* of this Contract.

1. The BH I/DD Tailored Plan Behavioral Crisis line must have patch warm transfer capabilities to the NC peer warm line (1-855-PEERS NC).

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

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.

[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.

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 NCGS § 108D-40(a)(9).
12. Beneficiaries who are residing in carceral settings other than prisons and whose Medicaid eligibility has been suspended, as provided in NCGS § 108D-40(a)(9a).

g. ***Section IV. E. Members, 3. Member Engagement, i. Written and Verbal Member Materials, ii., 4.*** **is revised to add the following:**

a. For all materials requiring a tagline, the PIHP shall use the Department-developed Auxiliary Aids and Interpreter Services Tagline Template.

h. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, c. Covered Medicaid Services, iii., 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. Third 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) • 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)

* Tribal Members who are Innovations Waiver beneficiaries are included in the population that may obtain listed services from the PIHP.
[2]CST includes tenancy supports.

Section IV.F.1. Third Revised and Restated Table1: Behavioral Health, I/DD, and TBI Services Covered by PIHP*

• Clinically managed population-specific high-intensity residential services
• 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 transition and support
  ○ Respite
  ○ Community living and supports
  ○ Community transition
• 1915(b)(3) Long Term Residential and Day Support Services

i. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, c. Covered Medicaid Services, iii., Section IV.F.1. First Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*** **is revised and restated in its entirety as follows:**

Section IV.F.1. Second Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
1	Outpatient services	
2.1	Intensive outpatient services	Substance Use intensive outpatient program
2.5	Partial hospitalization services	Substance Use comprehensive outpatient treatment
3.3	Clinically managed population-specific high-intensity residential services	Clinically managed population-specific high-intensity residential services
3.5	Clinically managed high-intensity residential services	Clinically managed residential services (substance abuse non-medical community residential treatment)
3.7	Medically monitored intensive inpatient services	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)
4	Medically managed intensive inpatient services	Medically managed intensive inpatient services (Inpatient BH services)
Office-based opioid treatment	Office-based opioid treatment	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment and
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory withdrawal management, without extended on-site monitoring (ambulatory detoxification) Ambulatory withdrawal management, with extended on-site monitoring
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.2-WM	Clinically managed residential withdrawal management	Clinically managed residential withdrawal services (social setting detoxification)

Section IV.F.1. Second Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
3.7-WM	Medically monitored inpatient withdrawal management	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)
4-WM	Medically managed intensive inpatient withdrawal	Medically managed intensive inpatient withdrawal management (Inpatient BH services)

j. *Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, d. Medical Necessity* is revised to add the following:

viii. Consistent with guidance from the American Academy of Pediatrics, the PIHPs shall apply the following professional standards in conducting an EPSDT medical necessity review:
1. Traditional evidence grading (patient-centered or scientific evidence for children) with a hierarchy or algorithm of standards applied;
2. Professional standards of care for children; or
3. Consensus expert pediatric opinion.

k. *Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, i,* is revised and restated in its entirety with no revisions to subsections 2.-5. 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 *Fourth Revised and Restated Table 6: Required Clinical Coverage Policies*., subject to the following:
1. The PIHP shall incorporate NC Medicaid Direct clinical coverage policies into its UM Program in accordance with *Section IV.F.1. Fourth Revised and Restated Table 6: Required Clinical Coverage Policies*.

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

Section IV.F.1 Fourth 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 • Mobile Crisis Management • Multi-systemic Therapy Services • Partial Hospitalization • Professional Treatment Services in Facility-Based Crisis Program • Psychosocial Rehabilitation (PSR) 8A-1: Assertive Community Treatment 8A-2: Facility-Based Crisis Services for Children and Adolescents 8A-5: Diagnostic Assessment

Section IV.F.1 Fourth Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	**Scope**
	8A-6: Community Support Team (CST) 8A-7: Ambulatory Withdrawal Management Without Extended On-Site Monitoring (ambulatory detoxification) 8A-8: Ambulatory Withdrawal Management With Extended On-Site Monitoring 8A-9: Opioid Treatment Program 8A-11: Medically Monitored Inpatient Withdrawal 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 8H-2 Individual Placement and Support 8H-3 Individual and Transitional Support 8H-4 Respite 8H-5 Community Living and Support 8H-6 Community Transition
Telehealth (for services within the scope of this Contract)	1-H: Telehealth, Virtual Communications and Remote Patient Monitoring

m. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, xviii. UM Policy for 1915(i) Services*** **is revised to add the following:**

8. The PIHP shall submit to the Department a monthly report of Members for whom the transition from 1915(b)(3) services to 1915(i) services is in progress and the PIHP's progress in completing the independent assessment for Members identified as in need of or requesting to receive 1915(i) services until all transitions are completed. The PIHP shall submit to the Department upon its request information regarding Member transitions to 1915(i) services for reporting to CMS.

n. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services (ILOS), ii.*** **is revised and restated as follows with no revisions to subsections 1.-7.:**

ii. Once each Contract Year, the PIHP shall submit to the Department for review and approval the Department's standardized ILOS Service Request Form for each proposed new ILOS or revision to an existing ILOS offered under the Contract, except that the PIHP may submit the standardized ILOS Service Request Form to the Department at any time to request termination or reduction of services offered as an ILOS.

o. ***Section IV. G. Care Management and 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 the annual requirements set forth in *Section IV.G.2.b.ii.4.* of this Contract for the percentage of Members actively assigned to an AMH+ or CMA for Provider-based Tailored Care Management. These AMH+/CMA providers are responsible for delivering at least one (1) of the following six (6) core Health Home services:
    a. Reserved;
    b. Reserved;
    c. Reserved;
    d. Reserved;
    e. Reserved;
    f. Reserved;
    g. Reserved;
    h. Reserved;
    i. Comprehensive care management;
    j. Care coordination;
    k. Health promotion;
    l. Comprehensive transitional care/follow-up;
    m. Individual and family supports; or
    n. Referral to community and social support services.
    o. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website, accurate as of April 25, 2025: https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center of Section V.4.2. the *Tailored Care Management Provider Manual*.

p. ***Section IV. G. Care Management and Coordination, 2. Tailored Care Management, b. Delivery of Tailored Care Management, ii. Provider-based Tailored Care Management, 5.*** **is revised and restated in its entirety as follows:**

5. The Department will assess compliance with annual percentages for each Contract Year during the first quarter of subsequent Contract Year, beginning in Contract Year Two. The percentage shall be calculated as:
    i. Numerator: Number of Members assigned to provider-based Tailored Care Management provided by care managers based in entities (AMH+ practices and/or CMAs) certified by the Department as measured on the first day of the first quarter of a new Contract Year.
    ii. Denominator: Total number of eligible Members assigned to any Tailored Care Management entity (AMH+ practice, CMA, or Plan-based care management) as measured on the first day of the first quarter of a new Contract Year.

q. ***Section IV. G. Care Management and Coordination, 2. Tailored Care Management, d. Enrollment in Tailored Care Management, ii., 1.-2.*** **is revised in its entirety as follows:**

1. The PIHP shall permit Members who do not want to participate in Tailored Care Management to opt-out via a Tailored Care Management Opt-out Form, which the PIHP shall submit to the Department for approval as part of its Care Management and Care Coordination Policy. The PIHP shall use the same Tailored Care Management Opt-out Form as the one used for the BH I/DD Tailored Plan contract. The form must include a place to provide the reason for opting out.

i. The PIHP shall permit the Tailored Care Management Opt-out Form to be mailed in, completed online, filled out in person with the care manager, or filled out over the telephone with either the PIHP or organization assigned to provide Tailored Care Management.

ii. If a Member opts out of Tailored Care Management, the PIHP shall disenroll the Member from Tailored Care Management by the last day of the month in which the PIHP received the Member's Tailored Care Management Opt-out Form. In the event that the PIHP receives the Member's Tailored Care Management Opt-out Form within the last three (3) Calendar Days of the month and is unable to disenroll the Member prior to the end of the month, the PIHP shall notify the assigned AMH+/CMA of the date on which the Member's opt-out request will become effective in NC Fast.

2. Reserved.

r. ***Section IV. G. Care Management and Coordination, 2. Tailored Care Management, d. Enrollment in Tailored Care Management, ii.*** **is revised to add the following:**

7. At least once annually, the PIHP shall attempt to reengage Members who have opted out of Tailored Care Management and for whom no Tailored Care Management claim has been submitted within the prior twelve (12) months.

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

i. The PIHP shall ensure that all members have a choice of care management approach (outlined in *Section IV.G.2.b. Delivery of Tailored Care Management*). To facilitate timely engagement in Tailored Care Management, the Department shall make Tailored Care Management assignments as described in the *Tailored Care Management Auto Assignment Requirements Document*. The PIHP shall make Tailored Care Management assignments for Medicaid members enrolled in the PIHP after November 30, 2022, using a methodology, consistent with the requirements in this Section.

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

ii. The PIHP shall ensure that all eligible Members have a choice of organization where they obtain Tailored Care Management.

1. Member choice must be processed in the assignment cycle following the Member's request. In the event the PIHP receives the Member's choice request with all information required to process the assignment request within the last three (3) Business Days of the month and is unable to complete the assignment process by the last day of the month, the PIHP must notify the Member of the effective date of their choice.

u. ***Section IV. G. Care Management and 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. 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.

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

vii. PIHP must assign Members to a mix of the three Tailored Care Management approaches (outlined in *Section IV.G.2. Tailored Care Management*) according to the factors described in the *Tailored Care Management Auto Assignment Requirements Document.*

w. *Section IV. G. Care Management and Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment and Re-Assignment, x.* is revised and restated with no changes to subsection 2. as follows:

x. In addition to the factors outlined in the *Tailored Care Management Auto Assignment Requirements Document*, the PIHP shall consider the following factors when assigning each Member to care management at an AMH+ practice or a CMA, or at the PIHP level.

1. Reserved.

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

xiii. The PIHP shall have a Tailored Care Management reassignment process that provides guidance for the assignment of Members who have significant changes in their needs and may be better served by a different care management approach (CMA, AMH+ or plan based care management). Member choice must be honored in any reassignment algorithm designed by the PIHP. The PIHP shall submit its policies and procedures for Care Management comprehensive assessments as part of its Care Management and Care Coordination Policy.

1. Member choice must be processed in the assignment cycle following the Member's request. In the event the PIHP receives the Member's choice request with all information required to process the reassignment request within the last three (3) Business Days of the month and is unable to complete the reassignment process by the last day of the month, the PIHP must notify the Member of the effective date of their choice.

y. *Section IV. G. Care Management and Coordination, 2. Tailored Care Management, f. Tailored Care Management Assignment and Re-Assignment* is revised to add the following:

xx. To ensure continuity of care, prevent misassignments and allow for Warm handoffs, the PIHP shall notify the Tailored Care Management entity from which the Member is being reassigned during each monthly reassignment cycle. By the end of the month, PIHP shall provide to the Tailored Care Management entity that the Member is leaving the following data:

1. The Member's Identification Number.
2. The name of the Tailored Care Management entity to which the Member is being reassigned; and
3. The reason that the Member is being reassigned.

xxi. If a PIHP is notified by an AMH+ practice, CMA, or the Department and/or independently identifies that a TCM Member who was reassigned to the PIHP should have remained assigned to AMH+/CMA TCM provider, the PIHP shall do all of the following:
    1. No more than sixty (60) Calendar Days after the PIHP has been notified that the Member should have remained assigned to the AMH+ Practice or CMA and within thirty (30) Calendar Days of submitting the Reassignment Attestation Form as required by *Section IV.G.2.f.xxii.b.*, the PIHP shall reassign the Member back to the AMH+ practice or CMA to which the Member should have remained assigned.
    2. Within the first week of the month, the PIHP shall submit to the Department through the PCDU a completed *Reassignment Attestation Form* to report:
        i. Each Member who was reassigned to the PIHP for Tailored Care Management in the prior month when that Member should have remained assigned to an AMH+ practice or CMA; and
        ii. The AMH+ practice or CMA to which the PIHP is working to reassign each Member.
    3. In accordance with *Section III.B.34.c.*, the PIHP shall make the Tailored Care Management monthly payment to the AMH+ practice or CMA to which the Member should have remained assigned for each month in which the Member was reassigned to the PIHP but should have remained assigned to the AMH+ practice or CMA for Tailored Care Management.

xxii. Within five (5) Calendar Days of the effective date of the Member's reassignment, the PIHP shall transmit the following data to the Member's assigned AMH+ practice or CMA:
    1. Member assignment information, including demographic data and any clinically relevant and available eligibility information;
    2. Pharmacy lock-in data including all mandatory fields and valid values noted in the data specification document;
    3. Member claims/encounter data, including historical physical, behavioral health, and pharmacy claims/encounter data. The PIHP shall transmit new physical health and/or behavioral health claims/ encounter data on a monthly cadence and pharmacy claims/ encounter data on a weekly cadence;
    4. Acuity tiering and risk stratification data. The PIHP receives the Member's acuity tier (e.g., low, medium, high) from the Department. The PIHP is required to transmit the Member's acuity tier to the Member's assigned AMH+ practice or CMA along with the results and methods of any risk stratification conducted by the PIHP; and
    5. Other data to support a Member's reassignment to an AMH+ practice, CMA or PIHP. The PIHP shall transfer current care plans, ISPs, care management assessments, ADT data, and historical Member clinical information to the member's assigned AMH+ practice, CMA or PIHP.

z. *Section IV. G. Care Management and Coordination, 2. Tailored Care Management, l. Ongoing Care Management for Members Engaged in Tailored Care Management, xii.-xiii.* is revised and restated in its entirety as follows:

xii. The Department will establish a standardized methodology to assign each Member to a Tailored Care Management acuity tier (e.g., high, medium, low).
    1. A Member's acuity tier represents the Department's estimate of the Member's care needs and necessary intensity of care management. This estimate does not supersede or otherwise override the clinical judgement of the assigned care manager.
    2. A Member's acuity tier is a combination of an alphabetical prefix followed by a numerical suffix that represents the Department's estimate of the Member's care needs and required intensity of care respectively.
        i. The alphabetical prefix may be one of the following values:

a. "BH", representing the Department's estimate that the Member has primarily behavioral health care needs or co-occurring behavioral health and intellectual/development disability care needs.
b. "IDD", representing the Department's estimate that the Member has primarily intellectual/developmental disability care needs.

ii. The numerical prefix may be one of the following values:
a. "01", representing the Department's estimate that the Member requires a low intensity of care.
b. "02", representing the Department's estimate that the Member requires a moderate intensity of care.
c. "03", representing the Department's estimate that the Member requires a high intensity of care.

iii. The Department will assign the alphabetical prefix and numerical suffix of "UN01" to a Member if the Department has not yet calculated an estimate of the Member's care needs, or otherwise lacks sufficient historical data to do so.

3. The Department assigns each Tailored Care Management eligible Member to an acuity tier and shares this information with the PIHPs, and to the Member's assigned AMH+ or CMA as a tool to inform decision-making related to Member needs (e.g., whom to prioritize for outreach, who may have significant immediate needs), care manager and supervising care manager assignments, and to inform risk stratification. Acuity tier information is a retrospective snapshot in time based on the Member's available medical history including historical claims data. A Member's care needs can change at any time and care managers are expected to use their clinical judgement on the intensity of care management necessary to support a Member.

xiii. The assigned Tailored Care Management entity shall use its clinical judgement and the results of the Member's comprehensive care management assessment to determine the frequency and type of contacts to be made based on the Member's needs. Nothing in this Section shall preclude the PIHP from reviewing the medical necessity of the frequency or format of Tailored Care Management contacts documented in the Member's care plan/ ISP and/or from requesting validation of the frequency or format of contacts delivered.

1. For Members who have consented to and engaged in Tailored Care Management, an in-person contact shall be conducted between the Member's assigned care manager and the Member, or with a Member's legally responsible person or Member's legal guardian in lieu of the Member, where appropriate or necessary. Care managers should tailor the number, frequency and type of contacts based on the Member's needs.
2. For Members who request accommodations due to relevant health conditions, contacts can be delivered, at the discretion of the assigned Tailored Care Management entity, using clinically-appropriate assistive technologies (e.g., speech-to-text application, secure platforms for two-way instant messaging/texting)
3. The PIHP shall document, or shall review to confirm that the assigned AMH+ or CMA documents, the Member's preferences for contact frequency and Member accommodation requests in the Care Plan/ISP reviewed with the Member's assigned care manager.
    i. If any changes are made to the Member's Care Plan/ ISP, including changes to the frequency of contacts, intensity of care management needs, and/or accommodation requests, the PIHP shall obtain, or shall review the Member's updated Care Plan/ISP to verify that the assigned Tailored Care Manager has obtained, the signature of the Member or their legally responsible person/guardian on the updated Care Plan/ ISP.
4. The PIHP shall conduct, and shall include in its contracts with AMH+ practices and CMA providers a term requiring that the assigned care manager/ extender/ supervising care manager conduct, care management contacts in a manner that ensures the security of protected health

information and complies with all state and federal laws, including HIPAA and requirements related to records retention.

i. If the care manager/ extender/ supervising care manager utilizes two-way real time video and audio conferencing or assistive technologies to conduct the care management contact with a Member, the care manager/ extender/ supervising care manager shall enable applicable encryption and privacy modes, Public facing audio/ video communication applications, such as Facebook Live, Twitch, or TikTok shall not be used to conduct care management contact(s).

ii. If the care manager/ extender/ supervising care manager conduct the care management contact using two-way instant messaging or texting with a Member who requests accommodations due to relevant, specific health conditions as determined by the care manager and documented in the Member's signed care plan/ ISP, the care manager/extender/supervising care manager and Member shall communicate using two-way instant messaging/texting via a secure portal that has met all Department-required security and privacy requirements.

5. Reserved.

aa. ***Section IV. G. Care Management and Coordination, 2. Tailored Care Management, p. Staffing and Training Requirements for Care Managers Delivering Tailored Care Management, xiii.*** **is revised and restated as follows with no revisions to subsections 1.-6.:**

xiii. The PIHP shall validate that care managers complete the training modules as set forth in the *Tailored Care Management Provider Manual*.

bb. ***Section IV. G. Care Management and Coordination, 2. Tailored Care Management, t. Certification of AMH+ Practices and CMAs, iii., 2.*** **is revised and restated in its entirety as follows:**

2. During Readiness Review, the PIHP or a designated Department contracted vendor may determine that the AMH+ practice or CMA is not ready to meet the requirements of the Tailored Care Management model. In this situation, the PIHP shall provide reasons to the Department why it proposes to decline to contract with that AMH+ practice or, CMA inclusive of technical assistance provided and why the AMH+ practice or, CMA is inadequate. For the purposes of calculating compliance with the requirement to contract with all certified AMH+ practices and CMAs, the Department reserves the right not to remove an AMH+ practice or CMA from the denominator of the calculation if it deems the PIHP's reasons for not contracting to be unsatisfactory.

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

2. To the extent that an AMH+ practice or CMA, the PIHP must conduct oversight of the CIN or Other Partner.

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

x. Reserved.

ee. ***Section IV. G. Care Management and Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management*** **is revised to add the following:**

xix. The Department shall monitor the PIHP's, adherence to the Tailored Care Management model; compliance with Tailored Care Management requirements outlined in this Contract and relevant

documents identified in *Section IV.A.1*.; and delivery of quality Tailored Care Management annually utilizing the TCM Statewide Monitoring Tool.

1. For a period of one (1) year from initial monitoring review of the PIHP by the Department's contracted vendor, the Department shall offer Technical Assistance to the PIHP to remediate quality and/or compliance issues identified through the use of the TCM Statewide Monitoring Tool.
2. The PIHP shall use the TCM Statewide Monitoring Tool to evaluate contracted AMH+ practices and CMAs' compliance with the *Tailored Care Management Provider Manual*; required Tailored Care Management terms in the PIHP's Tailored Care Management provider contracts; and delivery of quality Tailored Care Management.
    i. For monitoring and reviews conducted by the PIHP prior to January 31, 2026, the PIHP shall provide technical assistance to its contracted AMH+s and/or CMAs to remediate non-compliance or quality issues identified through the TCM Statewide Monitoring Tool.
    ii. For services furnished on or before the end of the first monitoring review and technical assistance period, except as to egregious noncompliance issues as determined by the PIHP, the PIHP shall not withhold payments or recoup payments made to an AMH+ practice and/ or CMA based on noncompliance or quality issues identified by the PIHP through use of the TCM Statewide Monitoring Tool.

xx. The PIHP shall document Tailored Care Management services provided to its Members and shall verify that assigned organizations providing Tailored Care Management to the PIHP's Members document Tailored Care Management service delivery in accordance with the *Tailored Care Management Provider Manual*.

1. The PIHP shall validate that AMH+ practices and CMAs assigned to deliver Tailored Care Management to the PIHP's Members are complying with Tailored Care Management Provider Manual standards for records management and documentation.
2. The PIHP shall take appropriate remedial action permitted under the terms of its contract with an AMH+ and/or CMA if the AMH+ and/or CMA is found by the PIHP to be noncompliant with *Tailored Care Management Provider Manual* documentation requirements.

ff. ***Section IV. G. Care Management and Coordination, 4. Care Coordination for Members with a BH Transitional Care Need, b. Priority Populations for Care Coordination Among Members with a BH Transitional Care Need, i.*** **is revised and restated in its entirety as follows:**

i. The Department defines Members with a BH transitional care need as:
    1. Members for whom a crisis service, including an emergency department visit for a mental health or substance use condition, has been provided as the first mental health or substance use service;
    2. Members being discharged from an inpatient psychiatric unit or hospital or Facility-Based Crisis or general hospital unit following admission for a mental health or SUD condition;
    3. Members being discharged from a nursing facility who have an unmet BH need;
    4. Other members as determined by the PIHP; or
    5. Members under twenty-one (21) years of age being released from a carceral setting, including but not limited to a state prison, juvenile detention center, youth development center, county/local/tribal jail.

gg. ***Section IV. H. Providers, 2. Provider Network Management, c. Provider Contracting, v. Tobacco-free Policy, 1.-3.*** **is revised and restated in its entirety as follows:**

1. Starting January 1, 2027, the PIHP shall contract with Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the

provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy shall include a prohibition on smoking combustible products and the use of noncombustible 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 shall include prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to individuals they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

2. Starting January 1, 2027, the following partial tobacco-free policy shall be required in Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities:
    i. 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.
    ii. Outdoor areas of the property under the 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.
        c. Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.
3. Provider Monitoring
    i. Starting January 1, 2027, the PIHP shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The PIHP shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The PIHP shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

hh. ***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 cultural and 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;
xix. A telephone number at the PIHP where a member can call to confirm the information in the directory;
xx. Website URL as applicable; and
xxi. Telehealth services offered.

ii. ***Section IV. H. Providers, 3. Provider Relations and Engagement, d. Provider Manual*** **is revised to add the following as a technical correction:**

ix. Reserved.

jj. ***Section IV. H. Providers, 4. Provider Payments, i., i.-iii.*** **is revised and restated in its entirety as follows:**

i. Prior to the effective date of the Tailored Care Management Health Home State Plan Amendment, the PIHP shall make a monthly Tailored Care Management payment as defined in *Section III.B.34.c.* of this Contract for any month in which an enrollee is assigned to the AMH+/CMA and the AMH+/CMA delivers at least one (1) care management contact for that enrollee. The Department will publish the established monthly Tailored Care Management rate through the Capitation Rate books. This payment is for delegated non-benefit care coordination functions and is not a care management service. The PIHP shall not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one (1) care management contact to the Member.
ii. Beginning on the effective date of the Tailored Care Management Health Home SPA, the PIHP shall make the Tailored Care Management payment as defined in *Section III.B.34.c.* of this Contract to the Tailored Care Management entity for each assigned Member to whom the Tailored Care Management entity delivered at least one Tailored Care Management service in the Month. The Tailored Care Management payment shall be a fixed rate prescribed by the Department. This Tailored Care Management payment shall not be placed at risk. The PIHP shall pay AMH+ practices or CMAs the Tailored Care Management payment for any month in which the Medicaid member is assigned to the AMH+/CMA and the AMH+/CMA delivers at least one (1) care management contact. The PIHP shall not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one (1) care management contact to the Member.
iii. Contacts delivered by the assigned care manager or care manager extender shall be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a contact to a member, the contact shall count as a qualifying contact and be eligible for payment.

kk. ***Section IV. J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, i., 1. Claims, ii.*** **is revised and restated in its entirety as follows:**

ii. The PIHP shall pay or deny a Clean Claim within thirty (30) Calendar Days of receipt of the Clean Claim.

ll. ***Section IV. J. Claims and Encounter Management, 2. Encounters, e. Submission and Frequency, i., 1. Timeliness, iv.*** **is revised and restated in its entirety as follows:**

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 value-based payments to Providers. A complete list of value-based payment types can be referenced in the Service Level Agreement (SLA) guidance document.

mm. ***Section IV. J. Claims and Encounter Management, 2. Encounters, e. Submission and Frequency, i., 2. Accuracy, ii.*** **is revised and restated in its entirety as follows:**

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 value-based payments to Providers. A complete list of value-based payment types can be referenced in the *Encounter Data Submission Guide*.

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

4. Historical Value-based Payment Encounters
   i. PIHPs shall submit no later than one hundred eighty (180) Calendar Days from the availability of additional value-based payment (VBP) encounter types within the EPS, all encounters for those VBP payment types made prior to the implementation of the new VBP encounter type. A complete list of VBP encounter types can be referenced in the *Encounter Data Submission Guide*.

oo. ***Section IV. L. Technical Specifications, 7. Testing, d.*** **is revised and restated in its entirety as follows:**

d. The PIHP will participate in all End-to-End testing with other Department partners as directed by the Department. This will include End-to-End testing prior to launch and may include periodic End-to-End testing as other technical processes and systems are modified or brought online. The Department, if deemed necessary for the project execution, shall develop and provide an End-to-End test plan aligned with specific requirements for the program all systems part of End-to-End testing. At a minimum, the End-to-End testing Plan shall include:
   i. High level description of the End-to-End Testing scope;
   ii. High level overall End-to-End duration;
   iii. Applications or systems that are part of the End-to-End testing; and
   iv. Integrations that are part of the End-to-End testing.

pp. ***Section IV. L. Technical Specifications, 8. PIHP Data Management and Health Information Systems, a.*** **is revised to add the following:**

vii. The PIHP shall utilize the 834 file, NC Tracks, HIE, and the PIHP's Network data to update AMH+ practices or CMAs in accordance with *Section IV.G.2.q*. of the Contract.

qq. ***Section IV. M. Innovations Waiver Services, 1.*** **is revised as follows with no revisions to subsection a.:**

1. The PIHP shall provide Innovations Waiver services for federally recognized Tribal members, Indian Health Services (IHS) eligible beneficiaries, and beneficiaries released from a carceral setting in accordance with NCGS § 108D-40(a) who are enrolled in North Carolina's 1915(c) Innovations Waiver. The PIHP shall provide Innovations Waiver services to eligible Members in accordance with this Section. For federally recognized Tribal members and IHS eligible beneficiaries enrolled in the Innovations Waiver, the requirements of this Section shall only apply if the Member did not select to enroll in the BH I/DD Tailored Plan.

rr. ***Section IV. M. Innovations Waiver Services, 3. Tailored Care Management, a. Eligibility for Tailored Care Management, v., 2.*** **is revised and restated in its entirety as follows:**

2. If the member is enrolled in the Innovations or TBI Waiver, when determining required care management contacts, the assigned organization providing Tailored Care Management shall:
   i. Comply with the Individual Support Plan (ISP) requirements set forth in federal law and regulations, the Innovations Waiver, *Clinical Coverage Policy 8P: Innovations*, and the TBI Waiver;
   ii. Incorporate the HCBS Monitoring Check Sheet into care management contacts; and
   iii. Furnish and document in the ISP contacts at the higher of the frequency and modality required under Innovations Waiver, *Clinical Coverage Policy 8P: Innovations*, the TBI Waiver, or *Section IV.G.2.l. Ongoing Care Management*.

ss. ***Section IV. N. Transitions to Community Living, 4. Behavioral Health Services, a. Access to Array and Intensity of Behavioral Health Services, i., 2.*** **is revised and restated in its entirety as follows:**

2. If a TCL member residing in an Adult Care Home and/or State Psychiatric Hospital indicates to the PIHP that they are not interested in community-based supportive housing, the PIHP shall consult with the TCL member to complete the Informed Decision Making Tool (IDM); and

tt. ***Section IV. N. Transitions to Community Living, 5. IPS Services, c. Improved IPS and ACT Supported Employment Services*** **is revised to add the following:**

v. For Members with SPMI receiving IPS services who may be at risk of placement in a congregate living facility, within thirty (30) Calendar Days of receiving the TCL member's IPS-Supported Employment Participant ACH In/At-Risk Checklist ("In/At-Risk Checklist") completed by the IPS provider, the PIHP shall review the Member's In/At-Risk Checklist to determine whether the In/At-Risk criteria defined by the Department have been met. To demonstrate that the Member has met In/At-Risk criteria, the PIHP shall submit to the Department the Member's In/At-Risk Checklist for each TCL and/or In/At-Risk Member or Recipient determined by the PIHP to meet the In/At Risk criteria defined by the Department.

uu. ***Section IV. N. Transitions to Community Living, 6. Quality Assurance and Performance Improvement, b.,*** **is revised and restated in its entirety as follows:**

b. In accordance with TCL QAPI guidance issued by the Department, the PIHP shall integrate TCL QAPI Plan elements into its overall QAPI and QMIP by September 2, 2024. Beginning with the report due August 14, 2024, and through May 31, 2025, the PIHP shall submit to the Department within forty-five (45) Calendar Days following the end of each quarter a TCL QAPI Progress Report regarding implementation of the TCL component of its QAPI Plan in accordance with TCL QAPI Guidance issued by the Department. Effective September 1, 2025, TCL QAPI Plan and activity reporting will be required annually as part of the regular QAPI and QMIP cycle, and all TCL QAPI Plan components shall be included in the annual Quality submissions.

vv. ***Section IV. N. Transitions to Community Living, 6. Quality Assurance and Performance Improvement,*** **is revised to add the following:**

c. The PIHP shall work cooperatively with the Department and the Department's designated contractor to participate in on-site interviews of individuals eligible for TCL and their providers, and desk reviews of TCL operations to evaluate compliance with the requirements of the TCL Settlement Agreement and this Contract, to include but is not limited to, the following domains:
   i. Community Based Supported Housing;
   ii. Community Based Mental Health Services;

iii. Supported Employment Services;
iv. Discharge and Transition Process;
v. Pre-Admission In Reach and Diversion; and
vi. Quality Assurance and Performance Improvement.

d. In accordance with the terms of the TCL Settlement Agreement, the PIHP shall attend monthly meetings of the Department Transition Oversight Committee monitoring implementation of the TCL Settlement Agreement. Upon the Department's request, the PIHP shall provide information to the Transition Oversight Committee as necessary to supplement reporting regarding:
   i. Discharge-related measures, including without limitation: housing vacancies, discharge planning and transition process, referral process and subsequent admissions, time between application for services to discharge destination, and actual admission date to community-based settings; and barriers.

ww. *Section IV. O. Clinically Appropriate Placement Living* is revised and restated in its entirety as follows:

1. For Members not in DSS custody and enrolled with the PIHP following the launch of CFSP, the PIHP shall take the following action upon receiving notification from DSS or from the hospital or the member's LRP, that a Member under eighteen (18) years of age remains in the Emergency Department for longer than twenty-four (24) hours and is ready for discharge or transfer to another facility to receive Medicaid State Plan behavioral health, I/DD and/or TBI services~~.~~:
   a. Within one (1) Business Day of receiving the notification described in *Section IV.O.1.* of this Contract:
      i. If the Member is not in DSS custody, the PIHP shall contact the Medicaid help center to open a case for the Member; or
      ii. If the Member in DSS custody, the PIHP shall:
         1. Confirm that the Member has an open case with the Department of Health and Human Services' Rapid Response Team as defined in N.C. Gen. Stat. § 122C-142.2(g) ("Rapid Response Team");
         2. If the Member does not have an open Rapid Response Team case, request on behalf of the Department that DSS open a Rapid Response Team case for the Member.
   b. Within three (3) Business Days of receiving notification that a Member is ready for discharge or transfer to another facility to receive Medicaid State Plan behavioral health, I/DD, and/or TBI services, the PIHP shall demonstrate best efforts to arrange for the Member to receive services in an appropriate placement with the approval of the Member's guardian or legally responsible person (LRP).
   c. Within seven (7) Business Days of receiving the notification described in *Section IV.O.1.* of this Contract for the Member or confirming/opening a Rapid Response Team case through the Medicaid help center, the PIHP shall develop a rapid response plan for the Member using the Department-developed *Rapid Response Plan* template and attach the completed *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case.
      i. Until the Member is discharged or transferred to a clinically appropriate setting for the receipt of medically necessary behavioral health, I/DD and/or TBI services, the PIHP shall update the Member's *Rapid Response Plan* on a weekly basis and shall attach the updated *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last submitted update.
      ii. The PIHP shall participate in all Department-led escalation calls to which the PIHP Plan is invited with advance notice related to arranging placement for the Member.

d. In the event that a Member is not placed within twenty-four (24) hours following the PIHP's receipt of notification described in *Section IV.D.6.a*. of the Contract, the PIHP shall include the Member on the PIHP's next weekly submission of the BCM-073-M report.

2. For Members not in DSS custody and enrolled with the PIHP following the launch of CFSP, the PIHP shall take the following actions upon receipt of notification from DSS that a Member under eighteen (18) years of age who has been taken into physical DSS custody; requires evaluation for or delivery of Medicaid State Plan behavioral health, I/DD and/or TBI services, including residential placement in a licensed facility (i.e., residential treatment and/or PRTF service); and is staying overnight in a DSS office, hotel or similar placement:
   a. Within one (1) Business Day of receiving the notification described in *Section IV.O.2.* of this Contract, the PIHP shall:
      i. Contact the Member's county DSS Director to confirm that the Member has an open Rapid Response Team case;
      ii. If the Member does not have an open Rapid Response Team case, request on behalf of the Department that DSS opens a Rapid Response Team case for the Member.
   b. Within three (3) Business Days of receiving the notification described in *Section IV.O.2.* of the Contract, the PIHP shall demonstrate best efforts to arrange for the Member to be appropriately placed to receive medically necessary behavioral health, I/DD, and/or TBI services. Unless the member is in an emergency, automatic referral to a hospital emergency department for services does not satisfy this requirement.
   c. Within seven (7) Business Days of receiving the notification described in *Section IV.O.2.* of this Contract for the Member, the PIHP shall develop a rapid response plan using the Department-developed *Rapid Response Plan* template and attach the completed *Rapid Response Plan* to the Member's open Rapid Response Team case in the Medicaid help center.
      i. Until the Member is placed in a clinically appropriate setting to receive medically necessary behavioral health, I/DD and/or TBI services and is no longer staying overnight in a DSS office or similar placement, the PIHP shall update the Member's *Rapid Response Plan* on a weekly basis and shall attach the updated *Rapid Response Plan* to the Member's open Rapid Response Team case in the Medicaid help center within seven (7) Calendar Days from the last submitted update.
      ii. The PIHP shall participate in all Department-led escalation calls relating to arranging placement for the Member.
   d. In the event that a Member is not placed in a clinically appropriate setting for receipt of medically necessary behavioral health, I/DD and/or TBI services within one (1) Business Day following the BH I/DD Tailored Plan's receipt of notification described in *Section IV.O.2.* of the Contract, the PIHP shall include the Member on the PIHP's next weekly submission of the BCM-073-M Report.
   e. The PIHP shall work with the Member's DSS Office to update the crisis/ safety plan for each Member staying overnight in a DSS office, hotel or similar placement while awaiting clinically appropriate placement and shall reasonably work with the DSS Office to arrange for the Member to receive medically necessary assessments, services, and supports while staying overnight in DSS office, hotel, or similar placement pending clinically appropriate placement.
3. A Member's need for services shall be determined through a clinical evaluation, completed by a licensed professional, that is adequate to determine the appropriate level of care.
   a. Within three (3) Business Days of receiving notification described in *Sections IV.O.1.* or *IV.O.2.* of this Contract, the PIHP shall arrange for the Member to receive a clinical evaluation, completed by a licensed professional, that is adequate to determine the appropriate level of care.

b. If the Emergency Department where the Member is awaiting discharge, Member's guardian or LRP, contracted provider, or external TCM provider or other person/entity denies the PIHP and/or its contracted Providers access to the Member to conduct and complete a clinical evaluation as described in *Section IV.O.3.*, the Department shall notify the Department within one (1) Business Day of being denied access to the Member.

4. Nothing in this Section requires the PIHP to arrange for placement outside the recommended level of care determined by the Member's clinical evaluation as described in Section IV.O.3, or outside of services available under the Member's Medicaid benefit plan or through State-funded services.
5. In the event that the parent, legal guardian or legal custodian of a Member under eighteen (18) years of age for whom the PIHP has received notification described in *Sections IV.O.1. or IV.O.2.* of this Contract rejects or refuses admission to an appropriate placement identified by the PIHP, the PIHP shall, within one (1) Business Day identify a mutually agreeable placement within the recommended level of care identified by the clinical evaluation described in *Section IV.O.* by, at minimum, addressing barriers to the Member's parent, legal guardian, or legal custodian accepting the appropriate placement, and shall continue efforts to identify a mutually agreeable placement until placement is achieved.

IV. <u>Modifications to Section VI. Contract Attachments A-W</u>

Specific Attachments are modified as stated herein.

a. *Section VI. Contract Attachments A-W* is named as *Section IV. Contract Attachments for PIHP.*

b. *Section VI. Second Revised and Restated Attachment A. PIHP Organization Roles and Positions* is revised and restated in its entirety as *Section VI. Third Revised and Restated Attachment A. PIHP Organization Roles and Positions* and attached to this Amendment.

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

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

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

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

g. *Section VI. Attachment L. Policies, 2. First Revised and Restated AMH+ Practice and CMA Certification Policy* is revised and restated in its entirety as *Section VI. Attachment L. Policies, 2. Second Revised and Restated AMH+ Practice and CMA Certification Policy* and attached to this Amendment.

h. *Section VI. Attachment L. Policies, 4. Second Revised and Restated Behavioral Health Services Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards* is revised

and restated in its entirety as *Section VI. Attachment L. Policies, 4. Third Revised and Restated Behavioral Health Services Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards* and attached to this Amendment.

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

j. ***Section VI. Attachment L. Policies, 7. First/Second Revised and Restated Approved <PIHP NAME> In Lieu of Services* is revised and restated in its entirety as *Section VI. Attachment L. Policies, 7. Second/Third Revised and Restated Approved <PIHP NAME> In Lieu of Services* and attached to this Amendment.**

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

l. ***Section VI. First Revised and Restated PIHP Catchment Areas* is revised and restated in its entirety as *Section VI. Second Revised and Restated PIHP Catchment Areas* and attached to this Amendment.**

m. ***Section VI. Attachment U. Historically Underutilized Businesses* is renamed and reserved as *VI. Attachment U. Reserved.***

V. Effective Date

This Amendment is effective July 1, 2025, unless otherwise explicitly stated herein, upon the later of the execution dates by the Parties, subject to approval by CMS.

VI. Other Requirements

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

VII. 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

PIHP Plan Name

_____ Date: _____

PIHP Plan Authorized Signature

Third Revised and Restated Attachment A. PIHP Organization Roles and Positions

Department requires that PIHP staff the following roles. Personnel described in this section, even if the titles are not the same, may perform functions for both the BH/IDD Tailored Plan Contract and the Medicaid Direct Prepaid Inpatient Health Plan Contract. Compliance with similar provisions in the BH I/DD Tailored Plan Contract will be deemed compliance for this Contract.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Supervising Care Managers	These individuals are responsible for overseeing assigned care managers delivering Tailored Care Management and care coordination. These individuals are responsible for reviewing all Care Plans and ISPs for quality control and providing guidance to care managers on how to address Members' complex health and social needs. These individuals are responsible for ensuring fidelity to the Tailored Care Management model.	• Must meet North Carolina Residency requirements. • If serving Members with BH conditions, must hold a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN). • Three years of experience providing care management, case management, or care coordination to the population being served. • Supervising care managers serving enrollees with an I/DD or a TBI must have one (1) of the following minimum qualifications: o A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; OR o A master's degree in a human service field and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; OR o A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI. • If an enrollee is dually diagnosed with a behavioral health condition and an I/DD or a TBI, PIHP and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the enrollee's care manager. • The Department will grant a one-time staff exception ('grandfathering') for specified PIHP staff that: o Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan Contract Award (July 26, 2021).

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		○ This exception is based on the staff enrollee possession the required number of years of experience, but not the required degree, degree type or licensure type.
2. Care Managers	These individuals shall be responsible for providing: • Integrated whole-person care management under the Tailored Care Management model, including coordinating across BH, I/DD, TBI, LTSS, and Unmet Health-Related Resource Needs; • Care coordination for Members with a behavioral health transitional care need; and • Care coordination for all Members	• Must meet North Carolina Residency requirements. • Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 waiver of experience requirement for Qualified Professionals. • For care managers serving enrollees with LTSS needs: ○ Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. ○ This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.
3. Full-time Care Management Housing Specialist(s)	This individual or these individuals act as expert(s) on affordable and supportive housing programs for Members and care managers. This individual or these individuals coordinate with relevant staff at Department or PIHP (e.g., Transition Coordinators and DSOHF staff).	• Must meet North Carolina Residency Requirements
4. Full-Time Transition Supervisor(s)	This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.	• Must meet North Carolina Residency requirements. • Must meet at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training.
5. Full-Time Transition Coordinator(s)	This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for: • Individuals who are moving from a state psychiatric hospital to supportive housing; and • individuals moving from a state developmental center or an ACH to a community setting.	• Must meet North Carolina Residency requirements. • Transition Coordinators serving individuals with SMI: ○ Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		○ Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. • Transition Coordinators serving individuals with I/DD or TBI: ○ Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD; or ○ Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. ○ PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
6. Full-Time Peer Support Specialist(s)	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members with BH diagnoses residing in a state psychiatric hospital or an ACH.	• Must meet North Carolina Residency requirements. • Must have NC Certified Peer Support Specialist Program Certification.
7. Full-Time In-Reach Specialist(s)	This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.	• Must meet North Carolina Residency requirements. • Must hold a Bachelor's degree in a human services field. • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians. • PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
8. System of Care Family Partner(s)	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to PIHP's System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold high school diploma or GED. • Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid services.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
9. System of Care Coordinator(s)	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to PIHP's System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold: o a Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; or o a Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems.
10. DSOHF Admission Through Discharge Manager	These individuals are responsible for: • Coordinating and/or performing transition functions and activities described in Section *IV.G. Care Management* for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. Coordinating and/or performing discharge planning functions for PIHP members who are not receiving transition functions and activities described in Section *IV.G. Care Management* DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as PIHP's liaison to ADATCs in the PIHP's region.	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: • Must meet North Carolina Residency requirements. • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: • Must meet North Carolina Residency requirements. • Must hold: o a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or o a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or o hold a Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
11. Member Appeal Coordinator	This individual manages and coordinates member appeals in a timely manner.	• Must meet North Carolina Residency requirements.
12. Member Grievance Coordinator	This individual manages and attempts to resolve Member grievances in a timely manner.	• Must meet North Carolina Residency requirements.
13. Full-Time Member Grievance Staff	These individuals work to resolve Member grievances in accordance with state and federal laws and this Contract.	• For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing grievances.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
14. Full-Time Peer Review and/or Member Appeals Staff	These individuals work to resolve Member appeals in accordance with state and federal laws and this Contract.	• Peer reviewers must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals.
15. Full-Time Member Services and Service Line Staff	These individuals coordinate communication with Members	• Must meet North Carolina Residency requirements.
16. Provider Relations and Service Line Staff	These individuals coordinate communications between PIHP and providers.	• Must meet North Carolina Residency requirements.
17. Provider Network Relations Staff	These individuals support the Provider Network Director in network development and management.	• Must meet North Carolina Residency requirements.
18. Provider Grievance Coordinator	This individual manages and resolves provider grievances in a timely manner.	• Must meet North Carolina Residency requirements.
19. Provider Appeal Coordinator	This individual coordinates and manages provider appeals in a timely manner.	• Must meet North Carolina Residency requirements.
20. Full-Time BH/SUD Utilization Management Staff	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing.
21. Full-Time I/DD Utilization Management Staff	These individuals conduct I/DD UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	• Must be a Qualified Intellectual Disability Professional, or Qualified Professional, in the area of Developmental Disabilities as specified in 42 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3.
22. Tribal Provider Contracting Specialist	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must meet North Carolina Residency requirements.
23. Liaison between the Department and the North Carolina Attorney General's MID	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must meet North Carolina Residency requirements.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
24. Special Investigations Unit (SIU) Lead	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, criminal justice, or pre-law, or have at least five (5) years of relevant experience. • Must complete CLEAR training or provide a timeframe as to when it will be complete.
25. Special Investigations Unit (SIU) Staff	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice, or have at least three (3) years of relevant experience.
26. Liaison to the Division of Social Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinated through local DSS offices, and serves as a primary contact to triage and escalate member specific or PIHP questions.	• Must meet North Carolina Residency requirements.
27. Waiver Contract Manager	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1915(i) SPA and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	• Must meet North Carolina Residency requirements. • Minimum of seven (7) years of management experience, preferably in human services
28. Housing Development Coordinator	The Housing Development Coordinator's job responsibilities shall include but not be limited to the following: 1. Map existing permanent supportive housing (PSH), PSH utilized by housed TCL individuals, and requested housing locations of TCL individual currently in pre-transition process. Utilize the map and other information sources to develop plans to target new stock development or access to untapped existing stock within the PIHP Region. 2. Engage public housing authorities (PHAs), Continuums of Care (COCs), and Balance of State (BoS) with PIHP, NCHFA, grant, and other housing resources to develop housing stock and access throughout the PIHP Region. 3. Develop regional housing databases for the PIHP's Region connecting public stock with private housing options for TCL staff. 4. Utilize public notices of newly initiated housing developments, assertively engage private developers linking them with PIHP, NCHFA, HUD, and other resources for tax credit, bond, loan assistance, and	• Must hold a Bachelor's degree with a least two years of experience working with individuals and the housing systems serving people with SMI/SMPI obtaining and maintaining PSH. This position shall apply these skills to the development of permanent supportive housing within the PIHP Region aligned with TCL.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	rehabilitation in exchange for access agreements for individuals with disabilities. 5. Technically assist existing TCL staff and TCL provider engagement with their improved access of computerized housing availability systems, giving priority to, and more effectively offering and getting access for, TCL individuals to Targeted Key Housing. 6. Specify the pre-housing, day-of housing, post-housing, and proactive separation prevention expectations during pre-tenancy and post-tenancy transition teams. 7. Ad hoc participation in Local Barriers Committee to address housing barriers and participation on Housing Separation and Root Cause Analysis meetings to address provider practices contributing to separations. 8. In collaboration with DHHS Regional Housing Coordinators, develop effective housing access materials, training, and systems for early identification of reasonable accommodation letter needs, consistently quicker registering of those accommodation letters with landlords, informal intervention strategies accommodation denials, and connection to legal support agencies to remedy unfair housing practices. 9. In collaboration with DAAS, improve timely communication between DHHS Regional Housing Coordinators, landlords and TCL service providers. 10. Work within the PIHP and with external housing providers to develop Enhanced Bridge Housing, TCL priority to PIHP or Public Housing Authority-held master leases, incentivized housing priority to landlords for TCL members, and other novel housing access approaches.	
29. TCL Quality Assurance (QA) Specialist	This position manages TCL Quality Assurance Performance Improvement (QAPI) activities. The TCL Quality Assurance Specialist job responsibilities shall include but not limited to the following: 1. Serve as the organization's TCL QAPI point of contact for DHHS and manage and coordinate the development and implementation of internal QAPI activities and implementation of State QAPI initiatives. 2. Develop, implement, and evaluate QAPI processes and procedures to monitor and ensure the quality and timelines of contracted TCL functions, including diversion, in-reach, discharge and transition planning, quality of	• Must hold a Bachelor's degree with a least two years of experience in QA, preferably in a behavioral or medical managed care environment.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	life survey administration, and Root Cause Analyses (RCAs). 3. Develop and implement procedures including member outcomes monitoring to ensure the quality of mental health and employment services and that the frequency and intensity of services are sufficient to help individuals achieve increased independence and community integration, housing stability, and reduced institutional contacts and incidents of harm. 4. Conduct regular review and analysis of TCL quality and performance measures, member surveys and assessments, incidents of harm, mental health and employment services data, institutional admissions, and other data sources to identify quality issues and performance deficits. 5. Design and implement Performance Improvement Projects (PIPs) and other QAPI processes to identify and address quality and performance issues. 6. Provide support for Local Barriers Committee to identify, aggregate, and report barriers to member community integration and transitions to and maintenance of supportive community housing. 7. Develop and strengthen processes as needed to ensure compliance with and timeliness of required provider reporting, member assessments and surveys, and other data submissions, including incidents of harm reporting via the DHHS IRIS system or its replacement, service outcomes assessments via NC-TOPPS, TCL Quality of Life surveys, and other required data submissions and reporting tools 8. Provide support as needed for TCL team members to develop and implement data collection tools and procedures to ensure all program requirements are met; to support tracking, monitoring, and reporting; and to evaluate and ensure the quality of TCL services and functions	
30. TCL Data Analyst	This position provides data support for TCL Quality Assurance Performance Improvement (QAPI) activities and required reporting and manages and carries out procedures to ensure TCL data accuracy. The TCL Data Analyst's responsibilities shall include but are not limited to the following: 1. Serve as the organization's TCL data quality point of contact for DHHS;.	• Must hold a Bachelor's degree with a least two years of experience in data management and analysis, preferably in a behavioral or medical managed care environment.

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	2. Manage, coordinate, and carry out TCL Data Integrity Plan procedures and activities, including development, evaluation, and refinement of procedures to support data quality; regular and ongoing data review, validation, and cross-database reconciliation (e.g., TCLD, CLIVe, internal client data management systems, NCTracks extracts provided by the Department); identification of data quality issues and solutions; and data cleaning to ensure timely data entry and updates and data accuracy; 3. Collect and aggregate data for required TCL reporting; 4. Conduct ongoing monitoring to ensure timely Quality of Life survey administration; and 5. Assist with analysis, summary, and interpretation of data related to Performance Improvement Projects, member surveys, and other QAPI processes to support identification of individual and systemic quality issues that require intervention or improvement and evaluation of the effectiveness of QAPI activities and initiatives.	
31. Supported Employment Specialist	This individual's job responsibilities shall include but not be limited to the following: 1. As the PIHP's point of contact, engage in statewide Departmental efforts to expand, improve, and standardize IPS service models such as NC CORE; 2. Assertively develop new Individual Placement and Support Supported Employment (IPS-SE) providers and provide technical assistance in the integration with conversion from a fee-for-service IPS model into a milestone payment model such as NC CORE; 3. Provide direct technical assistance to sustain existing IPS providers by working within the PIHP to implement a stable NC CORE payment model standardized by the Department; 4. Review all provider's current IPS Fidelity Reviews, technically assist with recommended improvements, develop plans of correction for long-standing provider fidelity issues, and when required by reviewers assist during IPS Fidelity Reviews; 5. Facilitate, technically support, record provider feedback, and invite trainers to in-network IPS Collaboratives that include ACT Employment Specialists, and Peer-run Entities involved in IPS support; 6. Ensure and improve providers' NC CORE linkage to Vocational Rehabilitation (VR)	• Must hold a Bachelor's degree and have at least two years of experience working with adults with SMI/SPMI. Preference for experience obtaining competitive employment for adults with SMI/SPMI (preferably utilizing Individual Placement and Supports (IPS), Vocational Rehabilitation, or other research-based employment model).

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	offices throughout the PIHP's Region, attend key statewide VR meetings, invite VR offices into IPS collaboratives, and assertively engage VR regional leadership to problem-solve and improve NC CORE service to TCL members; 7. Facilitate the expansion of benefits counseling within network providers, improve VR benefits counseling linkage, and when possible, improve relationships with Social Security Administration offices and IPS providers. Furthermore, serve as the point of contact with the Department for meetings involving the statewide benefits counseling electronic system; 8. Maintain the departmentally required TCL IPS data in conjunction with Quality Assurance and/or other related cross-functional PIHP departments; 9. Actively participate in local, regional, and statewide job development efforts with businesses and corporations wanting to competitively employ individuals with SMI/SPMI and link those efforts to their IPS providers' workforce of the individuals they serve; 10. Assist linkage between community colleges, universities, employer internships/apprenticeships, with IPS providers increasing TCL individuals' access to supported education, technical training, job certification, internships, and apprenticeships; and 11. As opportunities arise, facilitate network development of other researched-based supported employment models aligned with the Settlement Agreement such as Customized Employment, Microenterprise, and similar nationally recognized models.	
32. Outreach Diversion Specialist	North Carolina Certified Peer Support Specialist with experience working with adults with SMI/SPMI on eliciting choices, preferences, and vision to obtain the social determinants of health serving recovery including but not limited to housing, competitive employment/education, community activity, financial and food security, and pro-recovery relationships. This position applies these skills to Transitions to Community Living for individuals being considered for admission into an Adult Care Home (ACH) through the Referral Screening Verification Process (RSVP). The Outreach Diversion Specialist's job responsibilities shall include but not be limited to the following:	• Must meet North Carolina Residency Requirements • Must be a North Carolina Certified Peer Support Specialist (NC CPSS)

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	1. Educating the member (and their family, as appropriate) on the choice to the remain in the community); 2. Providing referrals and linkages to available individualized community-based supports and services; 3. Developing a Community Integration Plan for those who choose to remain in the community; and 4. Fully inform individuals/guardians about all the available alternatives to entry into an ACH and steps taken to address concerns and objections to the admission.	
33. PIHP Transition Coordinator	This individual shall be solely responsible for performing the following tasks for TCL members, which cannot be delegated to the Tailored Care Manager: (a) Convene a transition team; (b) Schedule and convene transition planning / personal care plan meetings; (c) Facilitate discussion of a crisis plan, disaster plan, and emergency plan; (d) Ensure housing and financial support needs of the TCL member are addressed; (e) Ensure health and safety monitoring needs of the TCL member are addressed; and (f) Plan for and facilitate check-ins between the final transition planning meeting and move-in of the TCL member at the community-based supportive housing.	• Must meet North Carolina Residency requirements. • Transition Coordinators serving individuals with SMI: ○ Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or ○ Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. • Transition Coordinators serving individuals with I/DD or TBI: ○ Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD; or ○ Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. ○ Must meet North Carolina Residency requirements.
34. Olmstead Manager	Provide coordination across PIHP program areas to assist the PIHP in putting in place an array of policies, procedures or practices that support the ADA/Olmstead integration mandate within the PIHP and its provider network.	• Must meet North Carolina Residency requirements. • Must hold: ○ A Bachelor's degree in an area specific to the program from an appropriately accredited institution and three years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience; **or**

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		○ Master's degree in an area specific to the program from an appropriately accredited institution and two years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience.
35. Housing Supervisor	Role involves but is not limited to the following: • Creating, editing, and implementing existing or new housing policy; • Integrating the housing team into the Plan's TCL efforts and process to develop, fund, and maintain access to supportive housing for TCL members; and • Closely work with the TCL quality assurance staff to provide data reported internally and externally on the Plan's catchment-wide housing strategy, development, access, TCL member tenure, and other housing related issues.	• Five or more years of full time experience working in the field of developing, managing, and/or coordinating access to affordable housing, including without limitation: (1) professional experience in successfully operating a Housing First Model as it applies to people with disabilities transitioning into their chosen community; (2) at least one year as a lead or supervisor of employees in an affordable housing program. • *Any existing staff employed by the PIHP prior to July 1, 2024 in a housing supervisor position shall be grandfathered and shall not be required to meet the qualifications set forth above.
36. TCL Program Manager	Role involves but is not limited to the following: • Facilitate cross-functional teams that create and implement recovery oriented, person-centered care plans; • Create and implement Housing First, Employment First, Integrated Care, Recovery-Oriented Care, and Social Drivers of Health policies and procedures; • Cross-functionally integrate TCL transition efforts across all PIHP departments, and supervise the elevation of transition barriers to the Plan's Local Barriers Committee; and • Closely work with the TCL quality assurance staff to provide TCL data reported internally and externally.	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. • Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management • *Any existing staff currently employed by the PIHP prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above
37. Barriers and Training Coordinator	Role involves but is not limited to the following: • Coordinate and help ensure staff completion of all trainings required by the Department pursuant to the Contract for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members; • Develop, coordinate and help ensure staff completion of any additional TCL in-person and virtual trainings which may be required or requested by the Department for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members or the PIHP's TCL efforts;	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. • Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management • *Any existing staff currently employed by the PIHP prior to July 1, 2024 in a transition

Section VI. Third Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	• Coordinate and facilitate BH I/DD Tailored Plan / PIHP's monthly Local Barriers Committee meetings, and track and facilitate any potential barrier issues and questions to be addressed by the BH I/DD Tailored Plan / PIHP and its Local Barriers Committee; • Develop the agenda for Local Barriers Committee meetings, and be responsible for maintaining and forwarding to the Department the minutes of each Local Barriers Committee meeting and the Local Barriers Committee tracker within 14 calendar days after each meeting; • Work collaboratively with Local Barriers Committee members, BH I/DD Tailored Plan / PIHP staff, and network providers to help ensure timely identification and reporting of local barriers; exploration of potential resolutions and mitigation steps for local barriers; and identification of potential barrier patterns, root causes, and any quality improvements needed to mitigate risk and help improve TCL outcomes; • Ensure the Department is notified of any urgent barriers and work collaboratively with the Department to address all unresolved local barriers; • Participate in ad hoc barriers intervention meetings scheduled by the Department; and • Facilitate the identification and tracking of barriers leading to housing separations for TCL members and where applicable, participate in the BH I/TT Tailored Plan / PIHP's root cause analysis process for deaths or level 3 incidents involving TCL members.	program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above

Fourth 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 *Fourth 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. Fourth 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. Fourth 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. Fourth 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. Fourth 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 and percent of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Per Wavier performance measure number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1

Section VI. Fourth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
	Numerator: Number of new C waiver participants who received an initial LOC evaluation.			
4.	Number and percent of annual Level of Care evaluations for Innovations Waiver enrollees which were appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
5.	Number and percent of New Level of Care evaluations appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
6.	Reserved.			
7.	Number and percent 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.	Number and percent 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.	Number and percent of 1915 (c) waiver Providers with a plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Number and percent of monitored non-licensed and non-certified Providers, who have been found to be out of compliance and have a plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Number and percent of monitored non-licensed, non-certified providers that are compliant with Innovations waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Number and percent of monitored provider~~s~~ agencies wherein all staff completed all mandated training for 1915(c) Waiver.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			
14.	Number and percent of beneficiaries reporting that their Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Number and percent 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.	Number and percent of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Fourth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
17.	Number and percent of individuals whose annual Individual Support Plan 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.	Number and percent of Innovations Waiver beneficiaries 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 percent of Innovations waiver participants whose Individual Support Plans were revised, as applicable, by the Tailored Care Manager 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.	Number and percent of new 1915(c) waiver beneficiaries receiving services according to their Individual Support Plan within forty-five (45) Calendar Days of Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Number and percent of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Number and percent of Innovations waiver beneficiaries reporting their Tailored Care Manager helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Number and percent of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percent of 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 beneficiary from additional harm, where indicated as a percent of all actions where protective actions were indicated.	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. Fourth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
27.	Number and percent 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.	Number and percent of Innovations Waiver beneficiaries not requiring medical treatment or hospitalization due to medication errors.	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.	Number and percent of incidents that were not critical involving Innovations Waiver enrollees referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Number and percent of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Annually Fiscal Year	November 1
32.	Number and percent of level 2 or 3 incidents where 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.	Number and percent of level 2 and 3 incidents reported within required state policy 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.	Number and percent 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.	Number and percent 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

Section VI. Fourth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
37.	The number and percent of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver for services rendered.	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
38.	Reserved.			
39.	Reserved.			
40.	Reserved.			
41.	Reserved.			
42.	Reserved.			
43.	Number and percent of Innovations Waiver enrollees who are receiving services as specified in the Individual Support plan.	NCDHHS	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
44.	Number and percent of Innovations Waiver Members 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.	Number and Percent of Innovations waiver Members under the age of 21 who had a primary care or preventative care visit during the Innovations Waiver year.	NC DHHS	Annually Fiscal Year	November 1
46.	Number and percent of Innovations Waiver applicants for whom a Level of Care evaluation is completed at the time services previously identified as being needed at a future time become necessary.	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
47.	Number and percent of capitation payments to the PIHPs that are made in accordance with the CMS approved actuarially sound rate methodology.	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
48.	Number and percent of level 2 or 3 incidents where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields.	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. Fourth 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
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.			

Section VI. Fourth Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
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
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 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 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	February 1 May 1 August 1 November 1

Section VI. Fourth Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
			April 1 – June 30	
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 who are age twenty (20) or 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

Fourth 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. Fourth Revised and Restated Attachment E. Table 1: BH 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 Opioid Treatment Program Services:* ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • *Child and Adolescent Day Treatment Services:* Not subject to standard	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Opioid Treatment Program Services:* ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard

Section VI. Fourth Revised and Restated Attachment E. Table 1: BH Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural 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	
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 • 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 • *Medically monitored intensive inpatient services (once policy is added)*	
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.*	

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

Section VI. Fourth 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 • Substance Use Intensive Outpatient Program • Opioid Treatment Program Service (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 Management services (Nonhospital medical detoxification) (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 psychiatric treatment
		  • 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)
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

Section VI. Fourth Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
		• 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) • Medically Monitored intensive inpatient services
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 • 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. Fourth 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
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 ~~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*	Within forty-eight (48) hours

Fourth 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 include in Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. If a Provider is not complying with applicable critical incident and/or death reporting requirements or the PIHP identifies trends in incident reporting, the PIHP shall utilize remedial measures available under the contract with the Provider, including but not limited to provider monitoring and corrective actions, to remedy the noncompliance and minimize the occurrence of preventable incidents.

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 within thirty (30) Calendar Days of receipt of the Clean Claim.
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

Starting January 1, 2027, 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 January 1, 2027, 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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Sixth 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 *Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements* and *Sixth 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. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
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
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

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
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 approved DHHS CWCN data template of members identified as CWCN per the PIHP Plan's Region.	Monthly
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

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
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
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

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
16. 1915(i) Transition Report	This report tracks the status of individuals transitioning to 1915(i) including assessment completion, assessment submission, and transition to 1915(i) services.	Monthly
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	Monthly TCM Provider contracting and integration status report.	Monthly
5. Data Elements for Enhanced Validation (DEEV) Report	Monthly report. PIHPs will leverage the template to support post-production monitoring for Tailored Care Management (TCM).	Monthly
E. In-Reach and Transitions		
1. IDD In Reach, Diversion, Transition Activity Report	This report is for IDD members related to: 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., 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). 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., 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). 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., 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).	Quarterly

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
2. SED In Reach, Diversion, Transition Activity Report	This report is for SED members related to: 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., 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). 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., 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). 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., 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, Transition Activity Report	This report is for TBI members related to: 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	Quarterly

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	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
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.		

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
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
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

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
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
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
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	Monthly

Section VI. Sixth Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	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. *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
5. TPL Recovery Match Report	Report detailing those claims upon which the PIHP has been unable to effectuate Third Party Liability (TPL) recovery within one (1) year of the date of service.	Monthly

Section VI. Sixth Revised and Restated Attachment I. Table 2: PIHP Data Extracts *(Effective July 1, 2025)*		
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.	[redacted]	

Section VI. Sixth Revised and Restated Attachment I. Table 3: PIHP Reporting Requirements for Healthy Opportunities Pilot (Required Only for PIHPs Participating in the Pilot) *(Effective July 1, 2025)*		
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.	[redacted]	

Section VI. Sixth Revised and Restated Attachment I. Table 4: TCL Reporting Requirements *(Effective July 1, 2025)*		
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 last day of the month for the prior month, or the first Business Day following the last day of the month if the last day 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)	Quarterly
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
6. TCL ACT and IPS Report	Monthly report to monitor the total number of individuals receiving ACT, In-reach, and transition supports; the number of individuals receiving IPS services, including those served by fidelity teams, and the total that are in the priority population; information on the individuals receiving fidelity IPS services, including In/At-Risk checklist and identification of new IPS or ACT teams	Monthly

Attachment L. Policies, 2. Second Revised and Restated AMH+ Practice and CMA Certification Policy

a. Background

i. Prior to PIHP launch, the Department will implement a direct process to certify provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs as described below and in the https://medicaid.ncdhhs.gov/tailored-care-management/for-providers#ProviderManual-4280 Tailored Care Management Provider Manual. This certification process will require providers to apply to the Department and be assessed against the criteria in this policy.

1. AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the BH I/DD Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD diagnosis; an I/DD; or a TBI. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at BH I/DD Tailored Plan launch, the Department's vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.
2. CMAs will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to TCM eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid or State-funded services, other than care management, to the TCM eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the TCM eligible population.

ii. Reserved.

b. Eligibility

To become certified as an AMH+ practice or CMA, an organization must meet the requirements for an AMH+ practice or CMA, given at *Section IV.G Care Management and Care Coordination.*

c. Organizational Standing and Experience Criteria

i. The organization must demonstrate that its past experience positions it to provide Tailored Care Management to the BH I/DD Tailored Plan population, specifically the subpopulation(s) for which it proposes to become a certified Tailored Care Management provider.

ii. All organizations entering the certification process, including prospective AMH+ practices, will be required to indicate one or more of the following specialty designation type(s):

1. Mental health and SUD
    a. Adult
    b. Child/adolescent

2. I/DD (not enrolled in the Innovations Waiver
3. TBI (not enrolled in the TBI Waiver)
4. Innovations Waiver
5. Co-occurring I/DD and behavioral health
    a. Adult
    b. Child/adolescent

iii. Organizations that specialize in BH must demonstrate their capacity to serve populations with both mental health and SUD needs. The organization must offer an array of services that is aligned with the needs of the target population(s) in North Carolina. The Department has a general expectation that each organization will be able to show at least a two (2) year history of providing services to the TCM eligible population in North Carolina. However, the Department encourages organizations to build new capacity for Tailored Care Management.

iv. The organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.

v. The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business.

vi. Tailored Care Management must be recognized by the organization's leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.

vii. The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.

viii. The Department (prior to PIHP launch) or PIHP (beginning at PIHP launch) will look for evidence of a strong governance structure.

ix. Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.

d. Staffing Criteria

i. AMH+ practices and CMAs must meet the same care management staffing requirements as the BH I/DD Tailored Plan. See *Section IV.B.3 Staffing and Facilities.*

ii. The evaluation of each provider organization's application for AMH+ or CMA certification will include gaining an understanding of the role of any CIN or other partners in supporting or facilitating Tailored Care Management.

1. Where AMH+ practice or CMA proposes to partner with a CIN or Other Partner-employed care managers share responsibility for specific functions and capabilities required for the AMH+ practice or CMA to deliver Tailored Care Management to the extent permitted under the Tailored Care Management Provider Manual, the Department (prior to BH I/DD Tailored Plan launch) or the PIHP (beginning at BH I/DD Tailored Plan launch) will look to ensure that care management is sufficiently integrated with the organization's practice team, as Tailored Care Management requires.
2. Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to:
    a. Approve hiring/placement of a care manager and
    b. Require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory.

i. CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support the Tailored Care Management model.
    1. Arrangements with CINs or Other Partners must include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states.
    2. Any subsidiaries of PIHPs, BH I/DD Tailored Plans or other health plans may not be considered CINs or Other Partners for the purposes of Tailored Care Management with the following exception:
        i. That AMH+ practice or CMA may decide to enter into arrangements with a BH I/DD Tailored Plan as an "Other Partner" for use of its IT products or platforms for care management, in order to meet the care management data system requirements.
    3. AMH+ practices and CMAs must meet the same requirements for clinical consultants as the BH I/DD Tailored Plan. See *Section IV.G.2 Tailored Care Management.*

e. Population Health and HIT Criteria

i. The AMH+ or CMA must have implemented an EHR or a clinical system of record that is in use by the AMH+ practice or CMA's providers that may electronically record, store, and transmit their assigned Members' clinical information, including medication adherence.

ii. The AMH+ or CMA must use a single care management data system. The care management data system can be a care management software platform or an EHR with a care management module, which allows care managers to perform the following care management functions, at minimum:
    1. Maintain up-to-date documentation of Tailored Care Management Member lists and assignments of individual Members to care managers;
    2. Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
    3. Electronically document and store the Care Plan or ISP;
    4. Incorporate claims and encounter data;
    5. Provide role-based access to and electronically share, if requested the Member's records with the Member's care team to support and coordinate care management, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
    6. Track referrals; and
    7. Allow care managers to:
        a. Identify risk factors for individual Members;
        b. Develop actionable Care Plans and ISPs;
        c. Monitor and quickly respond to changes in a Member's health status;
        d. Track a Member's referrals and provide alerts where care gaps occur;
        e. Monitor a Member's medication adherence;
        f. Transmit and share reports and summary of care records with care team members; and
        g. Support data analytics and performance and send quality measures (where applicable).

iii. The AMH+ practice or CMA must receive and use enrollment data from the PIHP to empanel the population in Tailored Care Management. To support outreach, engagement, assessment, and care planning, the AMH+ practice or CMA (or CIN or Other Partner with whom the AMH+ practice and/or CMA has partnered to support functions and capabilities required for delivery of Tailored Care Management) must be able to:
    1. Receive, in machine-readable format, and maintain up-to-date records of acuity tiers by Member, as determined and shared by the PIHP;

2. Receive, in machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the PIHP; and
3. Electronically reconcile the Tailored Care Management assignment lists received from the PIHP with its list of Members for whom it provides Tailored Care Management.

iv. The same requirements for use of ADT information apply at the PIHP level and AMH+ or CMA level. See *Section IV.G.2 Tailored Care Management.*

v. The same requirements for use of "NCCARE360" apply at the PIHP level and AMH+ or CMA level. See *Section IV.G Care Management and Care Coordination.*

vi. The Department expects that during the first two contract years, PIHP, AMH+ practices, and CMAs will rely on the standardized acuity tiering methodology described above Section *IV.G.2 Tailored Care Management* as the primary method for segmenting and managing their populations.

vii. As described in *IV.G.2 Tailored Care Management*, the PIHP will have the option of establishing their own risk stratification methodologies beyond acuity tiering; if they do so, they will be required to share all risk stratification results and methodologies used with AMH+ practices and CMAs.

viii. By Contract Year 3, as the Tailored Care Management model matures, AMH+ practices and CMAs will be expected to develop their own risk stratification approach, refining the data and risk stratification scores they receive from the PIHP to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices and CMAs' use of Member registries to track Members by condition type/cohort is encouraged, but not required.

ix. Annually, the AMH+ practice or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of Members and refine the services as necessary. The AMH+ practice or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.

f. Quality Measurement Criteria

i. After the launch of the PIHP, AMH+ practices and CMAs will be required to gather, process, and share data with the PIHP for the purpose of quality measurement and reporting.

ii. The Department will publish quality measure requirements each year. Elements of the list may be modified on a quarterly basis, but new measures will be added only during annual updates.

iii. AMH+ practices and CMAs may need to perform tasks including:
1. Abstracting data from Member charts;
2. Performing quality assurance to validate the accuracy of data in Member charts that is used for quality measurement purposes;
3. Using additional codes to fully document Member status and needs in order to improve the accuracy of quality measurement; and
4. Explaining to Members the purpose of certain state-sponsored surveys, how the state and PIHP will use survey results, and how their information will be kept confidential.

iv. As covered in *Section IV.G Care Management and Care Coordination,* BH I/DD Tailored Plans will be required to share interim performance reports with AMH+ practices and CMAs.

g. Other Tailored Care Management Criteria

i. AMH+ practices and CMAs must develop policies for communicating and sharing information with Members, their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.

ii. AMH+ practices and CMAs shall follow the same requirements regarding the delivery of care management contacts as defined in *Section IV.G Care Management and Care Coordination.*
iii. AMH+ practices and CMAs must meet the same requirements for Care Management Comprehensive Assessment that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
iv. AMH+ practices and CMAs must meet the same requirements for Care Plans and ISPs that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
v. AMH+ practices and CMAs must meet the same requirements for the composition of a care team that apply at the BH I/DD Tailored Plan level.
vi. By PIHP launch, the AMH+ practice or CMA must demonstrate the ability to electronically and securely transmit the Care Plan or ISP to each member of the multidisciplinary care team**.** *See Section IV.G Care Management and Care Coordination.*
vii. AMH+ practices and CMAs must meet the same requirements for ongoing care management that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
viii. AMH+ practices and CMAs must meet the same requirements related to addressing Unmet Health-Related Resource Needs that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
ix. AMH+ practices and CMAs must meet the same requirements for transitional care management that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
x. Care managers based at AMH+s and CMAs, as well as any supporting CINs or Other Partners, will be required to undergo the same training requirements as care managers based at BH I/DD Tailored Plans. *See Section IV.G Care Management and Care Coordination.*

Attachment L. Policies, 4. Third Revised and Restated Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards

A. Background

The BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards provides the PIHPs with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

B. Behavioral Health Services

i. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.

ii. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.

iii. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.

iv. Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification services): a Medicaid crisis service for the purpose of network adequacy standards.

v. Ambulatory withdrawal management with extended on-site monitoring: a Medicaid crisis service for the purpose of network adequacy standards.

vi. Clinically managed residential withdrawal services (social setting detoxification): a Medicaid crisis service for the purpose of network adequacy standards.

vii. Medically Monitored Inpatient Withdrawal Services (Non-Hospital Medical Detoxification): a crisis service for the purpose of network adequacy standards.

viii. Medically managed intensive inpatient withdrawal services (acute care hospitals with adult inpatient substance use beds): a Medicaid crisis service for the purpose of network adequacy standards.

ix. Reserved.

x. Reserved.

xi. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xii. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xiii. Medically managed intensive inpatient services (Acute Care Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.

xiv. Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.

xv. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xvi. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xvii. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xviii. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xix. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xx. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xxi. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.

xxii. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xxiii. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxiv. Urgent Care for Mental Health:

1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.

xxv. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards

xxvi. Emergency Services for SUDs: Services to treat life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxvii. Urgent for SUD.

1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.

xxviii. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

xxix. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

Attachment L. Policies, 5. Third 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 the Department as part of the Department's centralized credentialing process. The information about Tribal providers will be shared with the PIHP through the Department's existing process.

2) Scope

This Policy applies to the PIHP 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 the Tribal Payment Policy described below by developing and maintaining a written Tribal Payment Policy related to all IHCPs/Tribal providers regardless of the provider's contracting status consistent with the Department's Tribal Payment Policy:

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 NC Medicaid Direct.

b) Payment

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

(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 NC Medicaid Direct rate for services that do not have an applicable encounter rate.

(b) Those that are enrolled as FQHCs, but do not participate in the PIHP's Network, an amount equal to the amount the PIHP would pay a Network FQHC that is not an IHCP.

(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.

(3) The Indian Tribal (I/T/U) Home Health Fee schedule is posted on the Fee Schedule and Covered Codes Portal and specific to just the Tribe codes and rates.

(4) The Skilled Nursing Facility Fee schedule is posted on the Fee Schedule and Covered Codes Portal and specific to just the Tribe codes and rates.

ii) The PIHP shall comply with PIHP Contract *Section IV.D.1., Engagement with Tribes* of this Contract 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.

iii) All non-Office of Management and Budget (OMB) rates for Tribal payment follow the regular Medicaid Direct methodology and fee schedules for the PIHP, unless otherwise defined in the Tribal Payment Policy.

iv) Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the Office of Management and Budget (OMB) rate, for applicate AIR services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. The PIHP shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with PIHP shall continue to follow those arrangements. OMB Tribal rates for hospital inpatient and outpatient services are included and identified on the hospital fee schedule available on the Fee Schedule and Covered Codes Portal.

(1) If a Member seeks care at an Indian health provider out of state, the services to the Member should be reimbursed by the OMB rate if applicable.

v) To promote same day access and reduce barriers or burdens to a Member such as transportation or taking time off from work, providers receiving the AIR rate may receive encounters per day (single day of service) such as but not limited to follows:

(1) Medical;
(2) Dental;
(3) Behavioral; and,
(4) One (1) other such as optical

vi) Tribal entity claims will not add up to the AIR rate since the AIR rate is established for all federally recognized Tribes. NC Medicaid adopted the AIR (also known as the OMB rate) as the rate to be used for the reimbursement of services provided by CIHA.

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 within thirty (30) Calendar Days of receipt of the clean claim.

(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 services 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, the 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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Attachment L. Policies, 7. Second/Third Revised and Restated Approved *<PIHP NAME> In Lieu of Service*s

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. Second 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. The duration of service is up to 28 weeks maximum and provided per week.	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. The duration of service is 1 unit per week, with length of service (180 days)	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. FCT treats the youth and his/her family through individualized therapeutic interventions. Decrease in crisis episodes and inpatient stays. FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the length of stay and reduce the risk of readmission. The duration of service is 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. The interventions focus on rehabilitating member strengths and skills as well as linking the member to available resources to assist him/her in relearning a sense of accountability for his/her own behavior.	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. The duration of service is one unit for 9-12 months length of service.	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. Members experiencing a behavioral health crisis meeting Emergent or Urgent Triage Standards. BHCAI-Per Event-Per Diem (2-23 hours). Rapid Response-Per Diem (14 days or less).	Inpatient Psychiatric Hospitalization Facility Based Crisis Behavioral Health Urgent Care (BHUC)	Eligible population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for 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	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
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive	Residential Level II Family Type (TFC)	Eligible population Children, youth, and young adults with Serious Emotional Disturbance (SED) that have multiple mental health	H0032 - U5

	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 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. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW. The HFW process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.	Residential Treatment Services Level II Group Home	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). The duration of service is 9-12 months	
Short Term Residential Stabilization	Residential Supports provides individualized services and supports to enable a person to live successfully in a Group Home or Alternate Family Living setting of their choice and be an active participant in his/her community. The intended outcome of the service is to increase or maintain the person's life skills, provide the supervision needed, maximize their	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. The duration of service is 30 days for initial authorization and for	T2016 TF U5

	self-sufficiency, increase self- determination and ensure the person's opportunity to have full membership in his/her community. Residential Supports includes learning new skills, practice and/or improvement of existing skills, and retaining skills to assist the person to complete an activity to his/her level of independence. Residential Supports includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety. Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source. Residential Supports are provided to individuals who live in a community residential setting that meets the home and community-based characteristics. Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All unlicensed AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues. Respite may also be used to provide temporary relief to individuals who		concurrent is every 30 days. Services maximum is 180 days.	

	reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports.			
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 Complex Needs are the ages of 5 and under 21, with a developmental and/or intellectual disability and a mental health disorder diagnosis who are Medicaid eligible and at risk of not being able to return to or maintain placement in a community 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. Initial authorization is for 120 days and concurrent every 30 days.	H0018 HA

Attachment L. 7. Second 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 members aged 5-20 with Child MH/SU, including individuals with MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their condition and presenting symptoms. Youth are presenting in crisis, however, 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. Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation and reevaluation/assessment and further development of the crisis plan as needed.	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. Duration of Service is 1 unit a week, 24 units with length of service 6-months.	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 referrals.	Emergency Department Visit Inpatient Psychiatric Hospital Admission	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co- occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. The duration of service is per 1 unit per event (2 hours per episode)	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 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
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 members ages 3 and older and provides an alternative to Emergency Room and Inpatient Psychiatric Hospitalization for eligible individuals who have a mental illness and/or substance use disorder diagnoses. Rapid Care Services may be provided to members in crisis who need short-term intensive evaluation, which can include a multi-disciplinary team of individuals such as clinicians, psychiatrists, nurses, and peer support specialists. The member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation AND the individual's medical needs are stable and appropriate for this level of care. Duration of Service 1 unit per day-Maximus length of service is 23 hours.	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	Intensive In-Home Residential Treatment Level III	Target population includes members ages 3-20 with 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

	of intensive in-home treatment for at risk children and adolescents 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; 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. Duration of Service is monthly maximum of 6-months	
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. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are	Psychosocial Rehabilitation	Target population includes ages 18 and older for individual has receiving a comprehensive clinical assessment and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or Substance use disorder (SUD). Duration of service is 1-unit per week, 52 weeks.	H2017 U5

	based on medical necessity, person-centered, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the individual's Person-Centered Plan. This service was developed in response to COVID-19 state of emergency and intended to be used only during a state of emergency, natural disaster, or situation where member is unable to attend PSR on site due to personal extenuating circumstances.			
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 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.	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 the use of the CALOCUS or CANS, functional impairment is demonstrated to indicate this level of service. Duration of Service is 12-18 months	H0032 - U5

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. Third 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. (Per Event) 1-Per Person/This service is designed to be completed during regular and extended business hours of Tier III settings up of at least 12 hours; and up to 23 hours, 59 minutes in Tier IV settings.	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. Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is intended to promote permanency goals. FCT treats the youth and his/her family through individualized therapeutic interventions.	Intensive In-Home Services (IIHS) Psychiatric Residential Treatment Facility (PRTF)	Target Population include ages 03-21 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 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. Duration of Service is 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4
High Fidelity Wrap-around (HFW)	High Fidelity Wraparound (HFW) is an intensive, team based, 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 are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with	Level II Group Setting & Program Level II Family Setting & Program	Target Population includes ages 3-20 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. Duration of service is 12 months:	H0032 - U5

	complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. Typically, this would be for youth with primary mental health diagnosis with co-occurring substance use disorder or an individual with co-occurring intellectual or developmental disabilities in the mild-moderate range. High Fidelity Wraparound is also utilized in a pro-active manner to serve those high-risk youth that are involved with multiple agencies.			
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. Family Navigator is a way of working with children, adolescents and/or adults with an IDD or TBI diagnosis and who are experiencing challenges navigating the systems that can provide support for the health and well-being of this population. Family Navigator is a critical element of the habilitation model as it allows flexibility to meet member's particular needs in their own environment or current location (i.e. home, hospitals, jail, shelters, streets, etc.) using a variety of methods. It is designed as a short-term outreach and engagement service targeted to populations or specific member circumstances that prevent the	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Targeted Population includes ages 3-64 for members diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems. Service is designed to meet the needs of the member. Maximum per month is 40 units (15 minutes) per month	T2041 U5

	individual from fully participating in needed care for intellectual or developmental disability or traumatic brain injury.			
Acute and Subacute Services Provided in an Institute for Mental Disease	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 age 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. Providers must follow the requirements for inpatient level of care outlined in the Division of Medical Assistance (DMA) Clinical Coverage Policy (CCP) 8-B, Inpatient Behavioral Health Services.	Emergency Department Inpatient Stay	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.	0160

Attachment L. 7. Second 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 members age 4 and older with a mental health or SUD diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material); AND Member does not have service restrictions due to their NC Medicaid program eligibility category that would make them ineligible for this service. Duration of service is one unit equals one hour of service- 412 units with length of service 180 days.	H2021 U5
Critical Time Intervention Termination effective date: 03/31/2025	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	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 services, transition from homelessness in housing.	H0032 U5 HK

	through critical 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.			
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 served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. Members experiencing a behavioral health crisis meeting emergent or urgent triage standards. One unit per event-4-6 hours. One per crisis episode. If two visits occur within 30-90 days, the LME/MCO must be notified of the rapid recidivism.	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,	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. Duration of service is 6-months:	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4

	such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services. FCT 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 Services – Complex Needs Termination effective 11/30/2025	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. This service is provided in a small group home or alternative family living setting with very structured supports. Families are actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential treatment settings, such as the member's own home or family home. Duration of service is billed one per day/180 units with length of service 6-months.	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	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. Duration of service is billed as one unit = one event per day and will utilize a two-tiered billing system based on the amount of time spent at the site as outlined below. If a member receives less than 1.5 hours of intervention, the	S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High

	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).		applicable outpatient, psychiatric, or other CPT codes would be utilized. This level of care is generally used for a duration of 23 hours or less, with optimal utilization between four to six hours per event. Rapid Care Services may be provided up to 23 hours per episode and will be performed in a facility that operates 24/7/365 days a year under psychiatric supervision. This facility must be able to accept individuals who are currently under involuntary petition for first evaluations.	
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., 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.	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 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 Duration of service is 36-48 units per member/12 months; maximum of 18 months.	H0032U5
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

			Duration of service is one unit per week with a minimum of two hours combined therapy and coordination of care- 24 units with length of service 6-months.	
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 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.	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. This service targets youth abandoned in the ED who are also at risk of intervention from DSS. The expected outcome is that the ECR provider quickly engages the guardian(s), creates a crisis plan, and links the member to services to support the guardian's ability to allow the youth to return home. The service also includes youth in DSS custody (in a DSS foster home or DSS shelter) who are at risk of presenting to the ED as a measure to assist with maintaining the youth in the community. Additionally, the intent of this service is to work with youth who remain inpatient due to difficulty with discharge planning. 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.	H2011 U5 U1 weekly unit
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	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. Duration of service is 1-Unit per week-24 Units-6 months.	H0040 U5 HA

	therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED). The team members providing the direct interventions to the child and family may vary based on the needs of the individual. The team will have daily meetings to prioritize activities, share information, and discuss individual members. The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face-to-face within one to two hours.			
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. Duration of service is billed one unit per month/The service is expected to achieve outcomes within six to 12 months (six-12 units of service). Additional units may be authorized in exceptional cases as medical necessity dictates. Transitional Youth Services Specialists work closely with families and community members to help ensure the member is safe, engaging in positive peer activities, learning the life skills needed to support themselves, and working or pursuing education.	H2022 U5
Assertive Community Treatment Step Down (ACT SD) Termination effective date 12/31/2025	ACT SD service supports beneficiaries whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately	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

	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 functioning and wellness while providing support for continued recovery.			
First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) *New ILOS* Effective 07/01/2025	First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member's or beneficiary's first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-ACT benefits most from receiving services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration.	Assertive Community Treatment (ACT)	Target Population includes members must have NC Medicaid or NC Health Choice based on residence in a county located within Vaya's region and be enrolled in Vaya's Behavioral Health and I/DD Tailored Plan or NC Medicaid Direct PIHP; The member must between the ages 15-30 years old, currently experiencing first-episode/onset of psychosis. Duration of Service is one event (or per diem) defined as a 15-minute, face-to-face contact, lasting a minimum of eight minutes.	H0040 HK U5
Dual Diagnosis Capable (DDC) ACT *New ILOS* Effective 07/01/2025	Dual Diagnosis-Capable Assertive Community Treatment (DDC-ACT) is a team-based, multidisciplinary approach to providing comprehensive, strengths-based, and person-centered services to individuals with primary substance use disorder (SUD) needs	SAIOP Facility-Based Crisis	Target Population include ages 18 and older with with a primary SUD diagnosis and a co-occurring MH diagnosis. A member who is appropriate for this service needs assertive engagement to develop treatment motivation. The member does not benefit from receiving services across multiple, disconnected providers, and may be at greater risk of hospitalization, relapse, and/or incarceration.	H0040 HH U5

	and co-occurring mental illness who have challenges living independently in the community. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Integrated treatment improves quality of life for people with co-occurring severe mental health (MH) and substance use disorders by combining SUD services with MH services. It helps people address both disorders at the same time—through the same service organization by the same team of treatment providers.			

Fifth Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages

Table 1: Liquidated Damages for Compliance Issues

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
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
6.	Failure to open a Medicaid help center case or to confirm or request that DSS open a Rapid Response Team case as described in *Sections IV.O.1.a.* or *IV.O.2.a.* of the Contract within one (1) Business Day of the PIHP receiving a notification described in *Sections IV.O.1.* or *IV.O.2.* of the Contract.	$250 per Member per Calendar Day
7.	Failure to develop a *Rapid Response Plan* and attach the Rapid Response Plan to the Member's Medicaid help center or Rapid Response Team case within three (3) Business Days of the PIHP receiving notification described in *Sections IV.O.1.* or *IV.O.2.* of the Contract.	$250 per Member per Calendar Day
8.	Failure to update a Member's *Rapid Response Plan* and attach the updated *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last Rapid Response Plan update on a Member for whom the PIHP received notification described in *Sections IV.O.1.* or *IV.O.2.* of the Contract and who is staying in the Emergency Department, DSS Office, hotel, or similar placement while awaiting placement in a clinically appropriate setting for medically necessary behavioral health, I/DD, and/or TBI services.	$250 per Member per Calendar Day

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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.	[redacted]
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
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.

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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
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 ISP for a member who has consented to receive Tailored Care Management as described in *Section IV.G.2. Tailored Care Management* (including a failure by the Member's assigned AMH+ practice or CMA to develop or complete the required assessment, Care Plan, or ISP).	$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.	Reserved.	[redacted]

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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.	Reserved.	[redacted]
10.	Failure to timely document and honor a Member's request to opt out or opt back in to Tailored Care Management where the Member has submitted a Tailored Care Management Opt-out Form to the PIHP as described in *Section IV.G.2.d.ii.* of the Contract.	$250 per occurrence per Member
11.	Failure to ensure that the Member's choice of Tailored Care Management is processed as described in *Section IV.G.2.f.* of the Contract.	$250 per member per occurrence per member
12.	Failure to comply with minimum Transitional Care Management requirements for Members engaged in Tailored Care Management as described in *Section IV.G.2. Tailored Care Management* of the Contract.	$65 per occurrence per Member
13.	Failure to comply with minimum care coordination requirements for Members with a Behavioral Health transitional care need as described in *Section IV.G.2. Care Management* of the Contract.	$65 per occurrence per Member
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
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.	[redacted]
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.	[redacted]

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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
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 o*r 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

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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
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

Section VI. Fifth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
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	The PIHP shall meet or exceed ninety-nine percent (99%) of welcome letters and	The number of welcome letters and Member handbooks (mailed separately	Monthly	98.99% - 95%: $1,250 per month

Section VI. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	Welcome Letter and Member Handbook *Applies if the PIHP utilizes separate mailings to send components of the Welcome Packet*	Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	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.		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 Provider Welcome Packets mailed within the timeframes specified in *Section IV.H.3.b.iv Provider Relations and Engagement.*	The number of Provider Welcome Packet sent by the 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.	Quarterly	97.99% - 95%: $1,250 per quarter 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

Section VI. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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

Section VI. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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. *For purposes of this standard, medical encounters include value-based payments to Providers as specified in the Encounter Data Submission Guide.*	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
2.	Encounter Data Accuracy	The PIHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate. *For purposes of this standard, medical encounters include value-based payments to Providers as specified in the Encounter Data Submission Guide.*	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

Table 3: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot)

Section VI. Fifth Revised and Restated Attachment N. Table 3: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot) (Effective July 1, 2025)		
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

Attachment Q. Second Revised and Restated PIHP Catchment Areas

The Department has defined four (4) PIHP Catchment Areas within North Carolina. See **Table 1: List of Counties by PIHP Catchment Area** for the counties included in each of the four (4) PIHP Catchment Areas.

Table 1: List of Counties by PIHP Catchment Area

PIHP	Counties in Catchment Area
Alliance Health	Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake.
Partners Health Management	Burke, Cabarrus, Catawba, Cleveland, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, and Yadkin.
Trillium Health Resources	Anson, Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Guilford, Halifax, Hertford, Hoke, Hyde, Jones, Lee, Lenoir, Martin, Montgomery, Moore, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Randolph, Richmond, Robeson, Sampson, Scotland, Tyrrell, Warren, Washington, Wayne and Wilson.
Vaya Health	Alexander, Alamance, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rockingham, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey.

Attachment U. Reserved