Amendment Number

Contract #30-2022-007-DHB-X

Medicaid Direct Prepaid Inpatient Health Plan Contract

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

Purpose:

The purpose of this Amendment is to modify existing requirements and incorporate new requirements to the Contract.

- **a.** Modify requirements in *Section II. Definitions and Abbreviations;*
- **b.** Modify requirements in *Section III. Contract Term, General Terms and Conditions, Protections, and Attachments;*
- **c.** Modify requirements in *Section IV. Scope of Services*;
- **d.** Modify requirements In *Section V. Contract Performance,* and:
- **e.** Modify *Section VI. Contract Attachments* as specified herein.

The Parties agree as follows:

I. Modifications to Section II. Definitions and Abbreviations

Specific subsections are modified as stated herein.

a. ***Section II. Definitions and Abbreviations, A. Definitions*** **is revised and restated as follows:**

75. Exclusion Lists: Lists the PIHP must check to determine the exclusion status of the PIHP, or its subcontractors, as well as any person with ownership or controlling interest, or any agent or managing employee of the PIHP to ensure that the PIHP does not pay federal funds to Excluded Person(s) or entities including:
    a. State Excluded Providers List;
    b. U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
    c. The System of Award Management (SAM);
    d. The Social Security Administration Death Master File (SSADMF);
    e. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
    f. Office of Foreign Assets Control (OFAC).

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

203. RN/OT Evaluator Team: The PHIP'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.

204. **TCL Implementation Plan:** The final Implementation Plan developed by the Department and provided to the Independent Reviewer and United States Department of Justice pursuant to the Fifth Modification of the Settlement Agreement, which identifies how the State will meet the metrics and timelines for its implementation of each of the Settlement Agreement's requirements.

205. **In-Reach/Transitions to Community Tool:** The tool approved by the Department that documents the TCL members' transition preferences, choices, and goals recorded by the TCL in-reach specialist and given to the transition team as a basis for transition and person-centered planning.

206. **TCL Designated Tailored Care Management Provider:** Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA) that provides Tailored Care Management for TCL participants in accordance with the Department's Tailored Care Management requirements for TCL participants. Each TCL Designated Tailored Care Management Provider must be currently designated by the Department and endorsed by the PIHP in the region the AMH+ or CMA seeks to serve.

207. **TCL Housing Pilot:** The supportive housing pilot conducted by the Department in collaboration with participating PIHPs which will focus on streamlining the process for accessing and utilizing targeted housing units, allowing the PIHPs to develop and foster relationships directly with property managers.

208. **1115 Demonstration Waiver:** North Carolina's amended 1115 demonstration waiver to the federal Centers for Medicare & Medicaid Services (CMS). The waiver is the legal authority for the specific items of the Medicaid Managed Care transformation that require CMS waiver approval (waiver #11-W00313/4).

209. **Healthy Opportunities Pilot Program (the HOP program):** The Enhanced Case Management and Other Services Pilot Program authorized by North Carolina's 1115 Demonstration waiver, referred to as the "Healthy Opportunities Pilot Program." The Pilot program will evaluate the effectiveness of a set of select, evidence-based, non-medical interventions and the role of the Network Lead on improving health outcomes and reducing healthcare costs for high-need Medicaid Members. The Healthy Opportunities Pilot Program refers to the overall Pilot program.

210. **Lead Pilot Entity:** Has the same meaning as Healthy Opportunities Network Leads.

211. **Designated Pilot Care Management Entity:** The entity assuming care management responsibilities specifically related to the Healthy Opportunities Pilots. Designated Pilot Care Management Entities shall include, but shall not be limited to:

a. The PIHP;
b. Advanced Medical Home Plus (AMH+) practices; and
c. Care Management Agencies (CMAs).

212. **Healthy Opportunities Network Lead (Network Lead):** Formerly known as a Lead Pilot Entity (LPE), a Network Lead is an organization contracted with the Department to create and oversee a network of HSOs for the Healthy Opportunities Pilot. A Network Lead serves as a connection between PIHPs and HSOs and facilitates collaboration between health care and human service organizations for the Pilot.

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

214. **Pilot Implementation Period:** A period of time during which PIHPs, Network Leads, HSOs, and Designated Pilot Care Management Entities build the capacity and infrastructure to participate in the Healthy Opportunities Pilot and prepare for Pilot service delivery.
215. **Pilot Service Delivery Period:** A period of time during which Healthy Opportunities Pilot services are delivered to Pilot enrollees. The Pilot Service Delivery Period is divided into sub-periods to align with State Fiscal Years.
216. **Interpersonal Violence (IPV)-Related Healthy Opportunities Pilot Services (IPV-Related Services):** Any services authorized under the Healthy Opportunities Pilot to Members experiencing or at risk of experiencing interpersonal violence or other threats to personal safety, not only including services described in the Interpersonal Violence/Toxic Stress domain and the Cross-Domain categories of the Healthy Opportunities Pilot fee schedule, but also include any services in the Housing, Food, or Transportation domains set forth in the Healthy Opportunities fee schedule that are recommended to a Member to help address interpersonal violence. The Healthy Opportunities Pilot fee schedule is located on the NCDHHS Healthy Opportunities Pilots web page, and is amended from time to time.
217. **IPV-Related Service Data:** Any authorizations, Services, data, information, reports, invoices, or other sources of information relating to or referencing IPV-Related Services authorized to be furnished to a Member or actually furnished to a Member.
218. **IPV-Trained Individual:** All members of the PIHP's workforce (including PIHP's employees and contractors, whether or not they are Care Managers) with access to IPV-Related Service Data who have completed all Pilot-related IPV-trainings provided or approved in advance by the Department.
219. **IPV-Related Data Training:** All relevant trainings, each as provided or approved in advance by the Department, prior to PIHP's workforce initiating a Member contact or an initial Pilot assessment.
220. **Healthy Opportunities Pilot Duplicative Service** - A service is considered duplicative if it provides the same service or activity to a single individual that is available to that individual through a Medicaid/other service, (including In Lieu of Services (ILOS), Value-Added Services (VAS), 1915(i) services, and 1915(c) waiver services), State-Funded Services, or any other approved Medicaid authority outside of the 1115 demonstration, or other available federal/state/local publicly funded services.

c. ***Section II. Definitions and Abbreviations, B. Abbreviations and Acronyms*** **is revised to add the following:**

239. **IPV:** Interpersonal Violence
240. **PESA:** Pilot Eligibility and Service Assessment

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, 11: <u>CONTRACT ADMINISTRATORS:</u> For the Department, Department's HIPAA and Policy Coordinator for all Federal, State, and Department privacy matters:*** **is revised and restated in its entirety as follows:**

Name & Title	Andrew A. Albright, Privacy Officer
Physical Address	1985 Umstead Drive, Kirby Building Raleigh, NC 27603
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7747
Email Address	Andrew.a.albright@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

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

iii. Tailored Care Management Capacity Building Performance Incentive payments.
iv. Healthy Opportunities Pilot Program payments.

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

i. **Tailored Care Management Capacity Building Performance Incentive Program Payments**
   i. Beginning in Contract Year 1, and in accordance with 42 C.F.R. § 438.6(b)(2), the Contractor will be eligible to receive quarterly Tailored Care Management Capacity Building Performance Incentive Program payments for the achievement of certain milestones specified in *Section IV.K. Financial Requirements* and aligned with the State's Quality Strategy.
      1. Incentive payments will be separate from and in addition to the capitation payments and non-risk payments made to the Contractor under this Contract and will be specifically identified as the "performance incentive payment" in any distribution to the Contractor.
      2. The incentive payment is not premium revenue and will not be considered as such for purposes of calculating the Contractor's Medical Loss Ratio.
      3. In no event will payments exceed five percent (5%) of total capitation revenue that the Contractor receives during the Contract Year.
      4. Payments are for performance on a quarterly basis under the Contract Year in which the performance incentive arrangement is applied.
      5. The program will not be renewed automatically, but the Department may include the program in subsequent Contract Years. The Department will notify the Contractor ninety (90) Calendar Days prior to the distribution of additional funds if the program will be in effect for that Contract Year.

j. **Healthy Opportunities Pilot Program:** If the Contractor covers a Catchment Area that includes a Healthy Opportunity Pilot and provides Healthy Opportunities Pilot services under the Contract, the Contractor shall receive, separate from capitation payments and subject to availability, the following funds from the Department to use for the Pilot Program:

i. Capped Allocation

1. The Department will set an initial capped allocation amount for each Pilot Service Delivery Period as defined in *Section II. A. Definitions* and in the Department's Healthy Opportunities Pilot Payment Protocol.
2. The Department will notify Contractor of its capped allocation amount, including the amounts for Pilot service delivery payments and Pilot administrative payments, at least thirty (30) Calendar Days prior to the start of each Pilot Service Delivery Period.
3. The Department reserves the right to adjust Contractor's capped allocation during the Pilot Service Delivery Period based on actual spending on Pilot services or due to significant changes to enrollment from that assumed in the allocation formula (e.g., if the Department determines Contractor is at significant risk of not expending eighty percent (80%) of its allocation within the Pilot Service Delivery Period).
    i. Before adjusting Contractor's capped allocation, the Department will inform Contractor in writing at least sixty (60) Calendar Days prior to the adjustment, or a mutually agreed upon timeline by the Department and Contractor, that it is at risk of an adjustment and allow Contractor to submit a report explaining its anticipated spending through the remainder of the Pilot Service Delivery Period for the Department's consideration. Contractor shall submit this report within ten (10) Calendar Days of being informed by the Department that it is at risk of an adjustment.
4. Pilot Service Delivery Payments
    i. The Department shall distribute monthly payments to Contractor from the Pilot service delivery payment component of its capped allocation.
    ii. The Department shall distribute the first payment, equivalent to $1/12^{th}$ of the Contractor's Capped Allocation, at least thirty (30) Calendar Days prior to the Pilot Service Delivery Period.
    iii. The Department shall, monthly, distribute further Service Delivery payments to the Contractor based on fund utilization in a method and total amount to be determined by the Department, as outlined in the Healthy Opportunities Payment Protocol.

ii. Pilot Administrative Payments:

1. The Department shall distribute, as part of Contractor's capped allocation, Pilot administrative payments for Contractor to cover administrative costs associated with Pilot operations.
2. The Department shall determine the amount of Contractor's Pilot administrative payments.

3. The Department shall distribute the Pilot administrative payment for each Pilot Service Delivery Period at a frequency as defined in the Department's Healthy Opportunities Pilot Payment Protocol.

iii. Pilot Care Management Payments:

1. The Department shall make fixed payments to Contractor, and Contractor shall make Pilot care management payments to Designated Pilot Care Management Entities. The Department will determine Pilot care management payments and document them in the Department's Healthy Opportunities Pilot Payment Protocol.

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

d. *Section III. B. General Terms and Conditions* is revised to add the following:

51. OUTSOURCING: Any Contractor or Subcontractor providing call or contact center services to the State of North Carolina or any of its agencies shall disclose to inbound callers the location from which the call or contact center services are being provided. If, after award of a contract, the Contractor wishes to relocate or outsource any portion of performance to a location outside the United States, or to contract with a Subcontractor for any such performance, which Subcontractor and nature of the work has not previously been disclosed to the State in writing, prior written approval must be obtained from the Department. Contractor shall give notice to the using agency of any relocation of the Contractor, employees of the Contractor, Subcontractors of the Contractor, or other persons providing performance under this Contract to a location outside of the United States.

III. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

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

x. Healthy Opportunities Pilot Care Management Protocol: Tailored Plans/PIHPs

xi. Healthy Opportunities Pilot Payment Protocol: Tailored Plans/PIHPs

xii. Healthy Opportunities Pilot Transitions of Care Protocol: Tailored Plans/PIHPs

b. *Section IV. Scope of Services, A. Administration Management, 6. Staffing and Facilities, o. Organization Roles and Positions, viii.* is revised and restated in its entirety as follows:

viii. Reserved.

c. *Section IV. Scope of Services, A. Administration Management, 6. Staffing and Facilities, p. Physical Presence in North Carolina, vi*. is to add the following:

27. Liaison to the DSS;

28. Waiver Contract Manager~~.~~;
29. Housing Development Coordinator;
30. TCL Quality Assurance (QA) Specialist;
31. TCL Data Analyst;
32. Supported Employment Specialist;
33. Outreach Diversion Specialist; and
34. PIHP Transition Coordinator.

d. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, n.* is revised and restated in its entirety as follows:

n. The PIHP shall develop service line scripts for use by PIHP staff when talking with members, authorized representatives, and providers.
   a. All service line scripts shall be clear and easily understandable and reflect the specific requirements, policies, and procedures of the North Carolina market.
   b. The PIHP shall submit to the Department for approval a listing of topics which scripts will address and shall modify the script topics as required by the Department. Topics for scripts shall include, but not be limited to:
      1. Member resources, education and assistance to understand Medicaid benefits and benefits available through the PIHP and physical health services in NC Medicaid Direct;
      2. Resources, education, and assistance to understand State-funded services;
      3. PIHP benefits;
      4. PIHP Network;
      5. Service prior authorization process and status;
      6. Member Grievances, Complaints and Appeals processes, including information on available member supports;
      7. Care Management and Care Coordination services;
      8. Unmet Health-Related Resource Needs and the NCCARE360 resources;
      9. Provider contracting;
      10. Provider claim submission and adjudication issues;
      11. Ombudsman program;
      12. Transitions of Care; and
      13. Other topics as identified by the Department.
   c. All Member Service Line, Provider Service Line and Behavioral Health Crisis Line scripts are due no sooner than ninety (90) Calendar Days after launch, and they shall be approved by the Department. All service line scripts are due to the Department upon request and when any Significant Changes are made.

e. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, o.* is revised and restated in its entirety as follows:

o. The PIHP shall document all call center interactions with members authorized representative and providers. The record of contact must include:
   a. Current or potential member's name;
   b. Medicaid identification number (preferred);
   c. Channel of interaction/Service Line;

d. Phone number; and emergency or alternative number, if needed
e. Notes summary of current or potential member interaction (e.g., summary of issue, if issue was resolved or addressed, what information was provided by the PIHP's representative);
f. Record of the time and date of interaction;
g. Contact agent;
h. Resolution and/or if additional follow-up is or was required; and
i. Interpreter requests and the language requested.

f. *Section IV. Scope of Services, B. Program Operations, 1. Service Lines, s.* is revised and restated in its entirety as follows:

s. In all communications with Members, and their families, the PIHP shall comply with HIPAA and all other applicable confidentiality provisions set forth in State and federal law. The PIHP shall:
   a. Respond appropriately to inquiries by Members, and their family members (including those with limited English proficiency);
   b. Connect Members, family members, and stakeholders to crisis services, when clinically appropriate, twenty-four hours (24) per day, seven (7) days per week, 365 days per year;
   c. Provide information to members and their family members on where and how to access BH services; and
   d. Train its staff to recognize third-party insurance issues and member, grievances and appeals and to route these issues to the appropriate individual or PIHP department.
   e. The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers, if applicable. The PIHP is required to submit a request to the Department for review and approval for a call center used by the PIHP, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract.
   f. Secondary call centers are defined as any activities where Subcontractors or Vendors are performing duties directly related to Members or providers beyond the three (3) service lines specified in the Contract.

g. *Section IV. Scope of Services, C. Compliance, 2. Program Integrity (PI), c, i. Validation of Exclusion List Status* is revised and restated in its entirety as follows:

i. Validation of Exclusion List Status
   1. Reserved.
   2. The PIHP shall disclose to the Department within thirty (30) Calendar Days of PIHP's knowledge any disciplinary actions that have been imposed on any licensed providers or entities or their governing body related to fraud, waste, or abuse as defined within the Contract.
   3. The PIHP shall check, at the time of contracting and at least every month thereafter, the exclusion status of any agents, managing employees, or persons with an ownership or controlling interest in the PIHP or any of its delegated entities or subcontractors against the Exclusion Lists to ensure that the PIHP does not pay federal or state funds to Excluded

Persons or entities. The PIHP shall not be controlled by a sanctioned individual. 42 C.F.R. 438.602(d) and 42 C.F.R. § 438.808(a).

4. The PIHP shall take appropriate action upon identification that a person, agent, managing employee, delegated entity or Subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.
5. The PIHP shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:
    a. The name(s) of the Excluded Person(s); and
    b. The amounts paid to the Excluded Person(s) over the previous twelve (12) months.~~;~~
    c. Reserved

h. ***Section IV. Scope of Services, C. Compliance, 4. Third-Party Liability (TPL), j. Identification of Other Forms of Insurance*** **is revised to add the following:**

ix. The PIHP shall ensure providers have the capability to verify other insurance information through the PIHP's provider portal and Real-Time Eligibility Electronic Data Interchange (EDI) transactions 270/271. The PIHP shall provide an operational timeline to the Department for review and approval on how the PIHP will meet the requirements of this section by BH I/DD Tailored Plan Launch.

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

n. Bypass Third Party Liability Rules
    i. No later than BH I/DD Tailored Plan Launch, the PIHP shall adjudicate claims as the primary payer and bypass Third Party Liability edits for Medicaid covered Services that commercial insurance does not typically cover based on criteria in the Managed Care Billing Guide (Section 3.27 Other Insurance and Third-Party Liability Bypass Guidance Document).

j. ***Section IV. Scope of Services, D. Stakeholder Engagement and Community Partnerships, 4. Development of Housing Opportunities for Members, g. Education and Outreach, v.*** **is revised and restated in its entirety as follows:**

v. Reserved.

k. ***Section IV. Scope of Services, D. Stakeholder Engagement and Community Partnerships, 4. Development of Housing Opportunities for Members, g. Education and Outreach, vi., 3.*** **is revised and restated in its entirety as follows:**

3. Reserved.

l. ***Section IV. Scope of Services, E. Members, 3. Member Engagement, l. Member Welcome Packet ii.*** **is revised and restated in its entirety as follows:**

ii. The PIHP shall include the following in the initial member Welcome Packet :
    1. A welcome letter that notifies the Member of their enrollment in the PIHP and provides:

a. The effective date from which the PIHP shall begin health coverage for the member;
b. Information on how to access the online provider directory and how to request a hardcopy of the provider directory;
c. Information on how the Member can learn more about their health care choices;
d. Information on types of services to access through NC Medicaid Direct;
e. The toll-free service line numbers which a Member may call for the Member Service Line and Behavioral Health Crisis Line;
f. Information on care coordination and care management services, assigned Tailored care management entity, how to change a Tailored care management entity, why a member might be auto assigned to a Tailored care management entity and information on opting out for members who meet Tailored Care Management eligibility criteria;
g. Contact information for the Ombudsman Program; and

2. A current Member Handbook.
3. The PIHP may opt to send the Member Handbook separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.

m. ***Section IV. Scope of Services, E. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vii. Internal Plan Appeals 5*****. is revised and restated in its entirety as follows:**

5. The PIHP shall provide Members or his or her authorized representative, to the extent permitted by law, the Member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the PIHP (or at the direction of the PIHP) in connection with the Appeal. The PIHP shall provide the information to the Member free of charge within five (5) Calendar Days from the receipt of request for standard appeals and within two (2) Calendar Days from the receipt of request for expedited appeals. 42 C.F.R. § 438.406(b)(5).

n. ***Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, ii. UM Program Policy*** **is revised to add the following:**

7. No later than January 1, 2024, the PIHP shall provide a publicly available prior authorization look-up tool for BH I/DD services to providers to support timely prior authorization requests from providers. The prior authorization look-up tool shall include all BH I/DD prior authorization requirements and the tool shall be accessible without any login from a provider.

o. ***Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, IV.F.1 Table 6: Required Clinical Coverage Policies*** **is revised and restated in its entirety as follows:**

Section IV.F.1 Second Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	**Scope**

PIHP Services Note: *For these policies, PIHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.*	
Medicaid State Plan BH Services	8A: Enhanced Mental Health and Substance Abuse Services: • Child and Adolescent Day Treatment services • Intensive In-Home Services • Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization • Mobile Crisis Management • Multi-systemic Therapy Services • Partial Hospitalization • Professional Treatment Services in Facility-Based Crisis Program • Psychosocial Rehabilitation (PSR) 8A-1: Assertive Community Treatment 8A-2: Facility-Based Crisis Services for Children and Adolescents 8A-5: Diagnostic Assessment 8A-6: Community Support Team (CST) 8A-7: Ambulatory Withdrawal Management Without Extended On-Site Monitoring (ambulatory detoxification) 8A-8: Ambulatory Withdrawal Management With Extended On-Site Monitoring 8A-9: Opioid Treatment Program 8A-10: Clinically Managed Residential Withdrawal Services (social setting detoxification) 8A-11: Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification) 8A-12: Substance Abuse Intensive Outpatient Program 8A-13: Substance Abuse Comprehensive Outpatient Treatment 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 8D-3: Clinically Managed Low-Intensity residential Treatment Services (substance abuse halfway house) 8D-4: Clinically Managed Population-Specific High Intensity Residential Program 8D-5: Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) 8D-6: Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment)*:* 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

p. ***Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, xiii.-xiv.*** **is revised and restated in its entirety as follows:**

xiii. Any decision to deny a service authorization request or to authorize a service, within the scope of this contract, in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the member's BH or I/DD or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).

xiv. As part of the UM program, the PIHP shall adhere to the following prior authorization requirements.

1. The PIHP shall conduct prior authorization reviews using current clinical documentation and must consider the comprehensive range of the member's BH and I/DD needs, noting that alternative treatments or supports may be appropriate in light of a Member's complete clinical and other support needs.
2. The PIHP may require a referral for any BH or I/DD services except where specifically prohibited in this Contract and in federal or State laws, rules, or regulations.
3. The PIHP shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial for services that are not required to be provided by the LEA. However, PIHP may consider the IEP to contain evidence to support a determination that a Member may require active treatment.
4. Consistent with 42 C.F.R. § 438.206, the PIHP shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:
    i. Emergency services
        i. In accordance with 42 C.F.R. § 438.114, the PIHP shall not require members to obtain a referral or prior authorization before receiving emergency services.
        ii. The PIHP shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
        iii. The PIHP shall not refuse to cover emergency services based on the provider of such services, the hospital, or the fiscal agent not notifying the Member's PIHP of the Member's screening and treatment within ten (10) Calendar Days of presentation for emergency services.
        iv. The PIHP shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the PIHP's Network.
        v. The PIHP shall not hold a Member with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
        vi. The PIHP shall not deny payment for treatment obtained due to an emergency medical condition or as a result of the Member having been instructed by a representative of the PIHP to seek emergency services. For purposes of this

section, the term "representative" shall not include a contracted provider of the PIHP.

ii. BH services

i. For Medicaid State Plan BH services, the PIHP shall require providers to use the following BH or other Department approved level-of-care determination and screening as part of the PIHP's UM program. The Department reserves the right to change, in writing, these required screening tools:

1. Substance Use:
   a. American Society for Addiction Medicine (ASAM) for medical necessity reviews for all populations except children ages zero (0) through six (6); and
   b. The PIHP shall use EPSDT criteria when evaluating requests for services for all children.
2. Mental Health:
   a. Reserved.
   b. Reserved.
   c. Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.

ii. The PIHP shall not require members to obtain a referral or prior authorization for the first mental health or substance use assessment completed in a twelve (12) month period.

iii. UM for children and youth under age 21

i. Screening services for children and youth under age 21: The PIHP shall not require members to obtain a referral or prior authorization for children's screening services.

ii. School-based clinic services: The PIHP shall not require members to obtain a referral or prior authorization for behavioral health services rendered at school-based clinics.

5. The PIHP shall ensure members have and are aware of having direct access to services for which the Department does not allow the PIHP to require referral or prior authorization, as defined in this Section.

q. *Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, xvi.-xvii.* is revised and restated in its entirety as follows:

xvi. UM Policy for DSOHF facilities

1. The PIHP shall comply with the authorization and admission requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance with N.C. Gen. Stat. § 122C-261(f)(4) and *Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities*. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the PIHP shall first make every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may

also include specialized or wrap around services for special populations such as individuals with I/DD or dementia.

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

xvii. The PIHP shall adhere to the Department's Managed Care Clinical Supplemental Guidance, which supplements the NC Medicaid clinical coverage policies.

xviii. UM Policy for 1915(i) Services

1. For 1915(i) services only:
   a. The PIHP shall submit the Department designated 1915(i) assessment tool and necessary information to the Department or the Department's specified vendor for the purposes of completing the independent evaluation to determine eligibly for 1915(i) services in alignment with requirements at 42 C.F.R. § 441.715(d). The PIHP shall comply with any additional guidance released by the Department on the process for supporting the independent evaluation.
   b. The PIHP shall ensure that the independent assessment is used to guide the development of the Care Plan/ISP, and that the results of the independent assessment are not the sole basis for limiting the services requested or approved. The PIHP may use the independent assessment in conjunction with other information to reduce or deny requested services.
2. PIHP shall ensure that any request for authorization of 1915(i) services is consistent with and incorporates the desires of the member and that such desires are reflected in the member's Care Plan/ISP as required by 42 C.F.R. § 441.725(b), including the desired type, amount and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See *Section G. 11. Additional Tailored Care Management Requirements for Members Obtaining 1915(i) Services* for additional details.
   a. The member's care manager based at a PIHP, AMH+ or CMA shall discuss with the member the duration of the services desired by the member and shall ensure that the Care Plan/ISP requests authorization for each service at the duration requested by the member during the contract year
   b. The member's care manager based at PIHP, AMH+ or CMA shall assist the member in developing a Care Plan/ISP and shall explain options regarding the 1915(i) services available to the member.

3. The PIHP shall inform members that they may make a new request for 1915(i) services at any time by requesting an updated Care Plan/ISP.
4. Care managers based at a PIHP, AMH+ or CMA may not exercise prior authorization authority over the Care Plan/ISP.
5. The PIHP shall issue prior authorizations for all BH, I/DD, and TBI services covered under the 1915(i) SPA according to the requirements set forth in the service definitions that will be established by the Department.
6. The PIHP shall provide any additional information or reports requested by the Department as required by CMS for the 1915(i).
7. Upon the effective date of the 1915(i) SPA, the PIHP shall assess members currently receiving 1915(b)(3) services for transition to the 1915(i) during their birth month (or at the time when 1915(b)(3) services are requested by the member), to support transitioning all members on the 1915(b)(3) to the 1915(i) within one (1) year of the 1915(I) SPA effective date.

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

2. Prior to change, reduction or removal of an ILOS , the PIHP shall submit the Department's standardized ILOS Service Termination Form to the Department for approval. Upon approval of a change, reduction, or removal, the PIHP shall notify all impacted Members by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

s. ***Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services (ILOS) vi*****. is revised and restated as follows:**

vi. Reserved.

t. ***Section IV. Scope of Services, F. Benefits, 1. Behavioral Health and I/DD Benefits Package, g. In Lieu of Services (ILOS) vii*****. is revised and restated in its entirety as follows:**

vii. Value-Added Services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e)(1)(i). Prior to change, reduction or removal of a Value-Added Service, the PIHP shall submit the Department's standardized Value-Added Services Termination Form to the Department for approval. Upon approval of a reduction or removal, the PIHP shall notify Members who are actively receiving the applicable Value-Added Service, as determined by the PIHP, of the reduction or removal pursuant to the requirements of 42 C.F.R. § 438.10(c)(6) and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of change. If a change in a Value-Added Service is made for the betterment of the Value-Added Service, the PIHP shall update their Member website to reflect this change.

u. ***Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, l. Ongoing Care Management for Members Engaged in Tailored Care Management., xiii., 3*****. is revised and restated in its entirety as follows:**

3. If the Member is dually diagnosed with a BH condition and I/DD or TBI, care managers must abide by the same requirements outlined for members with the BH Acuity tier referenced in *Section V.B.3.ii.(x)(l)(1), Care manager contacts for members with BH needs*.

v. ***Section IV. Scope of Services, G. Care Management and Care Coordination, 2. Tailored Care Management, m. Transitional Care Management for Members Engaged in Tailored Care Management, iii*****. is revised and restated in its entirety as follows:**

iii. Reserved

w. ***Section IV. Scope of Services, G. Care Management and Care Coordination, 10. In-Reach and Transition from Institutional Settings, b. Eligibility for In-Reach and Transition Services, i., 2*****. is revised and restated in its entirety as follows:**

2. ACHs (members with SMI and I/DD);

y. ***Section IV. Scope of Services, H. Providers, 2. Provider Network Management, c. Provider Contracting*** **is revised and restated in its entirety as follows:**

c. Provider Contracting
   i. The PIHP contracts with providers shall comply with the terms of this Contract, State and federal law, and include required standard contracts clauses listed in *Section VI. Attachment F. Second Revised and Restated Required Standard Provisions for PIHP and Provider Contracts*.
   ii. The PIHP shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) Calendar Days after the Contract Execution.
      1. The PIHP may utilize proposed contract templates submitted to the Department for review prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
      2. Upon approval by the Department, the PIHP shall update submitted templates to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The PIHP shall discontinue use of previously submitted contract templates once an amended version is approved.
      3. After launch of the Medicaid Direct health plan, the PIHP shall submit newly developed contract templates to the Department for approval at least ninety (90) Calendar Days before use with providers.
      4. During contract negotiations with a provider, the PIHP may, without the Department's prior approval, make amendments to a previously approved provider contract template.
         i. Any change to a standard provision required by *Section VI. Attachment F. Second Revised and Restated Required Standard Provisions for PIHP and Provider Contracts*, is limited to those provisions outlined in *Section VI.*

Attachment F. Second Revised and Restated Required Standard Provisions for PIHP and Provider Contracts, a., except for a change to a provision located in subsections a.xxv. which must be prior approved by the Department.

ii. Reserved.

iii. Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirements in this Contract, or state or federal law.

iv. The PIHP shall submit an unapproved contract template to the Department for approval at least ninety (90) Calendar Days before use with providers, including amended previously approved templates with significant changes.

v. The PIHP may only make changes to the provisions required in *Section 3. b.* of *Section VI. Attachment F. Second Revised and Restated* Required Standard Provisions for PIHP and Provider Contracts, when directed to do so by the Department.

iii. The PIHP shall not include any provider (including ordering, prescribing, or referring only providers) in its Closed Network that is not enrolled in North Carolina Medicaid.

1. The PIHP shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract. This validation should be done at least monthly thereafter.

i. If the PIHP is made aware of providers included in their network file that are not actively enrolled in NC Medicaid, the PIHP shall remove the provider from the PIHP network File within one (1) Business Day of notification. The PIHP shall remove any provider from the PIHP Network File and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider.

iv. The PIHP shall not employ or contract with any person or entity appearing on one of the Exclusion Lists.

v. Tobacco-free Policy

1. Starting July 1, 2024, 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 ~~the~~ 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 July 1, 2024, 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 July 1, 2024, 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.

vi. The PIHP shall offer to contract with a provider interested in joining the Closed Network in writing.
    1. All offers shall include the standard provisions for provider contracts found in *Section VI. Attachment F. Second Revised and Restated Required Standard Provisions for PIHP and Provider Contracts*, including the prescribed provisions located therein.
    2. If within thirty (30) Calendar Days the potential network provider rejects the request or fails to respond either verbally or in writing, the PIHP may consider the request for inclusion in the Medicaid network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the PIHP shall not consider the request rejected.
    3. The PIHP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers or otherwise prohibit a provider from providing services for or contracting with any other PIHP.

vii. The PIHP shall not require individual practitioners, as a condition of contracting with PIHP, to agree to participate or accept other products offered by the PIHP nor shall the PIHP automatically enroll the provider in any other product offered by PIHP. This requirement

shall not apply to facility providers. Notwithstanding the foregoing, this requirement shall not preclude the PIHP from requiring individual practitioners, as a condition of contracting with the PIHP, to provide BH I/DD Tailored Plan Services.

viii. The PIHP shall give written notice to any provider with whom it declines to contract within five (5) Business Days after the PIHP's final decision in accordance with 42 C.F.R. § 438.12(a)(1).

ix. The PIHP shall, with regard to payment to any provider or Subcontractor that is "related to" the PIHP, comply with the requirements in *Section IV.A.3. Readiness Review Requirements* and *Section IV.K.2. Medical Loss Ratio*.

x. The PIHP shall include a provision in the provider contract regarding a provider's right to file a Grievance or Appeal (as described in *Section IV.H.5. Provider Grievances and Appeals*) in its contract with providers. The PIHP shall include a notice in all provider contracts that the internal Appeal process with the PIHP must be exhausted before seeking other legal or administrative remedies under state or federal law.

xi. The PIHP shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:
    1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    2. Any information the Member needs to decide among all relevant treatment options.
    3. The risks, benefits, and consequences of treatment or non-treatment.
    4. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. Section 1932(b)(3)(A) of the SSA; 42 C.F.R. § 438.102(a)(1)(i)-(iv).

xii. The PIHP shall include a provision in the provider contract that requires providers notify the PIHP when a Member in a high acuity clinical setting is being discharged.

xiii. The PIHP may utilize evergreen contracts, i.e., a contract that automatically renews, with providers on the condition that the contract also includes provisions regarding how the contract may be terminated or non-renewed.

xiv. In contracting with providers, the PIHP shall comply with all applicable provisions in accordance with *Section VI. Attachment F. Second Revised and Restated Required Standard Provisions for PIHP and Provider Contracts*.

xv. The PIHP shall include in provider contracts that participating providers shall not submit claim or encounter data for services covered by Medicaid and PIHPs directly to the Department.

xvi. DSOHF Facilities
    1. The PIHP shall contract with the following Division of State-Operated Healthcare Facilities' alcohol and drug treatment centers, psychiatric hospitals, developmental centers, and children's residential facilities for inpatient and outpatient services for all levels and types of services provided or offered by the DSOHF facilities:
        i. Julian F Keith ADATC,
        ii. Reserved,
        iii. Lakeside,

iv. Woodside Treatment Center (State funded),
v. Cherry Hospital,
vi. Broughton Hospital,
vii. Central Regional Hospital,
viii. Caswell Developmental Center,
ix. Iverson Riddle Developmental Center,
x. Murdoch Developmental Center, and
xi. Whitaker Psychiatric Residential Treatment Facility.

2. The PIHP shall consider these DSOHF facilities to as having successfully completed the State's Centralized Credentialing and Re-credentialing Process (CCRP) and be enrolled as a provider in the NC Medicaid program.
3. The PIHP shall use a Department-developed contract template to contract with these DSOHF facilities, to be delivered by the Department after contract execution.

xvii. The PIHP shall contract with all Cross-Area Service Programs (CASPs) located throughout the State. A listing of the current CASPs is distributed annually with the state-funded Continuation Allocation letter. The PIHP shall use the PIHP's approved standard contract for all providers who are CASPs.
xviii. The Department may at its discretion require the PIHP to use a Department-developed contract template of other state-owned providers.
xix. For any provider subject to a rate floor as outlined in *Section IV.H.4. Provider Payments*, a PIHP may include a provision in the provider's contract that the PIHP will pay the lesser of billed charges or the rate floor only if the provider and the PIHP have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision, with the exception of the Durable Medical Equipment and the Physician Administered Drug Program rate floor. A PIHP shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

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

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

aa. *Section IV. Scope of Services, H. Providers, 4. Provider Payments* is revised to add the following:

u. The PIHP shall monitor the Department website and other Department communication mechanisms daily for changes to the NC Medicaid Direct rates to ensure compliance with the provider payment requirements herein. For provider payment requirements that refer to Medicaid Direct rates:
i. The PIHP shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change as prescribed by the Department.

ii. The PIHP shall implement applicable rate changes within agreed upon timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable provider.

v. Innovations Waiver Services-Direct Care Worker Rate (DCW) Increases

i. For dates of service on or after July 1, 2023, the PIHP shall increase reimbursement rates to Innovations waiver services providers for designated services (as identified in the November 22, 2023 NC Medicaid Innovations Waiver Provider Rate Increase Provider Bulletin) by amounts no less than the amounts prescribed by the Department relative to the rates in place as of February 2020 pre-COVID plus the required HCBS DCW rate increases effective March 2022. The PIHP shall implement the reimbursement rates consistent with the timeline requirements of *Section IV.J.1.d.iv.4),* except that reprocessing for a given provider who completes the attestation must occur prior to the later of seventy-five (75) days following contract execution or thirty (30) days following receipt of provider attestation. The PIHP shall implement the Innovations waiver services DCW rate increases consistent with SL 2023-134, Section 9E.15 requirements, including requiring provider attestation prior to payment and utilizing the Department's standard template to meet verification requirements. The PIHP shall provide documentation collected from providers to support the SL 2023-134, Section 9E.15 requirements upon request by DHB as defined in Section III.B.37. For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section IV.J.1.d.iv)*.

1. Reimbursement increases for designated Innovations Waiver services shall be no less than the per unit reimbursement increases communicated through Medicaid provider bulletins.

ii. The Department shall maintain and share with the PIHP a list of Innovations services and codes that the rate increase will apply to through the PCDU and the DHHS Website.

iii. The PIHP shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to specific providers to account for any changes to provider eligibility for enhanced reimbursement. The PIHP shall not recoup without approval of the Department.

iv. The PIHP shall communicate to contracted providers that the reimbursement increase is contingent on the Provider completing the Attestation and continuing to meet the eligibility criteria in SL 2023-134, Section 9E.15.

w. Payment for 1915(i) Services

i. The PIHP shall reimburse providers for 1915(i) services at no less than one hundred percent (100%) of the equivalent 1915(b)(3) services as of June 30, 2023. Equivalent 1915(b)(3) services are defined below in *Section IV. H. Table 1.: 1915(b)(3) Services Transitions to 1915(i).*

Section IV. H. Table 1.: 1915(b)(3) Services Transitioning to 1915(i)	
1915(b)(3) Services	**1915(i) Services**
In-Home Skill Building	Community Living and Support
One-time Transitional Costs	Community Transition
Individual Support	Individual and Transitional Support
Transitional Living Skills	

Intensive Recovery Supports	
Respite	Respite
Supported Employment	Supported Employment

x. Payment for Individual Placement and Support
   i. For dates of service on or after October 1, 2023, the PIHP shall increase reimbursement rate for providers of Individual Placement and Support (IPS) services no less than the rate prescribed in Clinical Coverage Policy ($26.40 per 15-minute unit as of October 1, 2023), unless the PIHP and provider have mutually agreed to an alternative payment arrangement. For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section IV.J.1.d.iv*).

y. 1915(i) Services DCW Rate Increases
   i. For dates of service on or after January 1, 2024, the PIHP shall increase reimbursement rates to 1915(i) providers for designated services (as identified in NC Medicaid Behavioral Health Services Rate Increases Provider Bulletin) by amounts no less than the amounts prescribed by the Department relative to the 1915(b)(3) rates in place as of February 2020 pre-COVID plus required HCBS DCW rate increases effective March 2022. The PIHP shall implement the reimbursement rates consistent with the timeline requirements of *Section IV.J.1.d.iv.4*). For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section IV.J.1.d.iv*).
   ii. The Department shall maintain and share with the PIHP a list of 1915(i) DCW and codes that the rate increase will apply to through the PCDU and the DHHS Website.
   iii. The PIHP shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to specific providers to account for any changes to provider inclusion in enhanced reimbursement.
   iv. The PIHP shall communicate to contracted providers that the reimbursement increase is contingent on the Department continuing to include 1915(i) services in the list of services supported by these DCW rate-related reimbursement increases.

z. Payment for Outpatient Behavioral Health Services
   i. For dates of service on or after January 1, 2024, the PIHP shall reimburse providers for the following Outpatient Behavioral Health services no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.
      1. Psychiatric Diagnostic Evaluation
      2. Development/Psychological Testing and Evaluation
      3. Therapeutic, Prophylactic, or Diagnostic Injection
      4. Office Visit Evaluation and Monitoring Codes for Psychiatrists and Psychiatric Nurse Practitioners
      5. Psychotherapy
      6. Psychotherapy for Crisis
      7. Family/Group Therapy
      8. Electroconvulsive Therapy
      9. Tobacco Cessation
      10. Screening, Brief Intervention, and Referral to Treatment

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

aa. Payment for Enhanced Mental Health Services

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

1. Community Support Team
2. Assertive Community Treatment
3. Multi-Systemic Therapy
4. Intensive In-Home Services
5. Partial Hospitalization
6. Child and Adolescent Day Treatment
7. Psychosocial Rehabilitation
8. Peer Support
9. Behavioral Health Long-Term or High Risk Intervention Residential

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

bb. Payment for Research Based Intensive Behavioral Health Treatment Services

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

cc. Hospital Payments for Behavioral Health Claims

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

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

i. 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 timely process the claim. The PIHP shall have the capability to request additional information via x12 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 x12 277 and electronic method (portal or email) no later than the launch of the BH I/DD Tailored Plan. 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.

cc. *Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii.* is revised and restated in its entirety as follows:

iii. Claim Submission Timeframes:

1. For any claims with a date of service prior to BH I/DD Tailored Plan Launch:
    i. The PIHP shall-allow 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.
2. 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 sixty-five (365) Calendar Days from the date of enrollment for health care provider and health care provider facility claims.

dd. ***Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties, 4.*** **is revised and restated in its entirety as follows:**

4. The PIHP shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website.
    i. The PIHP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates, including sending notification of overpayments, within an additional thirty (30) Calendar Days of implementing fee schedule changes.
    ii. This standard is only applicable for NC Medicaid rate floor programs.
    iii. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section.

ee. ***Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, h. National Correct Coding Initiative (NCCI), ii.*** **is revised and restated in its entirety as follows:**

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

ff. ***Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, h. National Correct Coding Initiative (NCCI), ii, a), 1.*** **is revised and restated in its entirety as follows:**

1. Reserved.

gg. ***Section IV. Scope of Services, J. Claims and Encounter Management, 1. Claims, h. National Correct Coding Initiative (NCCI), ii, c), 3*****. is revised and restated in its entirety as follows:**

3. The PIHP shall submit the NCCI File Certification form by the fifteenth (15th) Calendar Day of the next month following the receipt of the Non-Public Medicaid NCCI Edit Files from the Department confirming the following:
    i. The PIHP has received and downloaded the Non-Public Medicaid NCCI Edit Files from the Department; and
    ii. The PIHP has loaded the Non-Public Medicaid NCCI Edit Files, as provided to the PIHP by the Department, and are ready for use by the PIHP by no later than 12:00 AM EST on the first day of the calendar quarter in which the edit files apply.

hh. ***Section IV. Scope of Services, J. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, i.*** **is revised as follows:**

i. The PIHP shall submit all claims processed as encounters, as defined in this Section and in the Encounter Data Submission Guide, and each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, accuracy, and reconciliation.

ii. ***Section IV. Scope of Services, J. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency*** **is revised the add the following:**

ii. The PIHP shall ensure that all HIPAA transactions adhere to the Department Encounter Data Submission Guide and Companion Guides - 837I and 837P developed by the Department or its vendor(s) to be provided at Contract Execution.

iii. The PIHP shall establish connectivity to the relevant Department encounter systems in
accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
iv. The PIHP shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Data Submission Guide and Companion Guides – 837I and 837P.
v. Encounter data submissions must contain adjustments made by PIHP due to payment errors and/or provider adjusted claims.
vi. The PIHP shall submit a monthly certification from the PIHP Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.
vii. The PIHP is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).
viii. Specifications
    a. Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department's two publications, Encounter Data Submission Guide and Companion Guides - 837I and 837P.
    b. The PIHP shall follow the detailed process outlined in the Encounter Data Submission Guide. Encounters are defined in the group below:
        i. Medical, including ILOS, value added services, and Healthy Opportunities pilot services.
    c. The PIHP shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
        i. The PIHP shall have the capability to submit to the Department encounter data from:
            1. Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
            2. Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.
    d. The PIHP shall reference the same edit codes as the Department's system, which are defined in the Department's Encounter Data Submission Guide and Companion Guides - 837I and 837P.

jj. ***Section IV. Scope of Services, J. Claims and Encounter Management, 4. Data Validation and Processing*** **is revised and restated in its entirety as follows:**

4. Data Validation and Processing
    a. The PIHP shall have the capability to access sufficient enrollment information to perform member and service provider matching on all claim and/or encounter transactions, if necessary.

b. The Department shall utilize data validation protocols on encounter data files to assess PIHP encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).
c. The PIHP shall perform testing with the Department prior to system changes when clinical policy changes that may impact operational transactions (i.e., encounter submissions) are identified by PIHP or by Department. The PIHP shall not implement any system changes until testing is approved by the Department.
d. The PIHP shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.
e. The PIHP shall, in instances where the PIHP is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) Calendar Days prior to the date the modified file will be submitted to the Department production environment.
f. The PIHP shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.
g. At the discretion of the Department, the PIHP may be prohibited from submitting a specific encounter type to the Department's Production Encounter Processing System if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan to monitor necessary improvements from the PIHP. In addition, if the PIHP's access to the Production Encounter Processing System is revoked, the PIHP must actively test with the Department until such time that the compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) Calendar Days. Any liquidated damages incurred by the PIHP because of the loss of production access are the responsibility of the PIHP.

kk. *Section IV. Scope of Services, J. Claims and Encounter Management, 5. Denied Claims Submitted as Encounters* is revised and restated in its entirety as follows:

5. Denied Claims Submitted as Encounters
   a. The PIHP shall submit denied claims as encounters to support denial trend analysis, excluding claims rejected at the HIPAA or EDI level.
   b. PIHP submissions of denied claims as encounters must adhere to data quality editing and limited program editing.
   c. On denied claims submitted as encounters, the PIHP shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
   d. Denied claims submitted as encounters must also include the same data content, including provider, Member, and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.
   e. The PIHP shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction.

ll. ***Section IV. Scope of Services, J. Claims and Encounter Management, 6. Communication and Oversight*** **is revised and restated in its entirety as follows:**

6. Communication and Oversight
    a. If the PIHP experiences a technical issue preventing encounter data submission, the PIHP shall notify the Department via the approved communication method within the predefined timeline.
    b. The PIHP shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the PIHP's system(s) or process(es) that prevents the PIHP from submitting encounter data files as scheduled.
    c. The PIHP shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
    d. The PIHP shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.

mm. ***Section IV. Scope of Services, J. Claims and Encounter Management, 7. Testing is*** **revised and restated in its entirety as follows:**

7. Testing
    a. The PIHP will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the PIHP to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The PIHP shall pass the testing phase for all encounter claim type submissions at a time specified by the Department.
    b. The PIHP shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Data Submission Guide and Companion Guides – 837I, 837P.

nn. ***Section IV. Scope of Services, K. Financial Requirements*** **is revised to add the following:**

5. Tailored Care Management Capacity Building Performance Incentive Program
    a. To qualify for the Tailored Care Management Capacity Building Performance Incentive Program, the Contractor must develop and submit a Capacity Building Distribution Plan for Departmental approval. The Contractor shall use the Department-approved template, detailing how Contractor will invest in care management capacity and Tailored Care Management providers in its Tailored Plan Region to achieve specific milestones. In completing the Capacity Building Distribution Plan, the Contractor shall set quarterly targets associated with each milestone. The Capacity Building Distribution Plan template, including the list of milestones and additional guidance on the submission and approval process will be published on the PCDU. Submission and approval of the Capacity Building Distribution Plan is a milestone, and the Contractor will receive the initial incentive payment following the approval of the Capacity Building Distribution Plan.

b. To receive incentive payments in addition to the initial payment described in subsection (i), Contractor shall submit on a quarterly basis the Tailored Plan Capacity Building Quarterly Report, due thirty (30) Calendar Days after the end of each calendar quarter, following April 1, 2023. Contractor shall use Department-defined template, showing the milestones and associated targets that have been met and a list of participating AMH+ practices and CMAs. Quarterly incentive payments are contingent on the Contractor meeting targets/milestones. Contractor will receive funding associated with targets/milestones that are proportionate to progress on those targets/milestones and level of effort and resources required to meet them. If the Contractor does not make progress on a target or milestone, for that quarter, the Contractor will not be eligible to receive the funding associated with that target/milestone. For any quarter where the Contractor does not meet a target/milestone, Contractor will be eligible to receive funding in a future quarter when the targets/milestones are met. The Capacity Building Quarterly Report template and timeline for submission of all quarterly reports will be published on the PCDU.
    i. Contractor shall submit Capacity Building Monthly Reports, due on the last day of each month so long as the Contractor Distribution Plan has been approved by the Department. Contractor shall use the Department -defined template, with progress updates on achieving milestones. The Capacity Building Monthly Report template will be published on the PCDU.
    ii. Contractor shall re-submit an updated Capacity Building Distribution Plan for Department approval along with the Capacity Building Quarterly Report, if Contractor's Capacity Building Distribution Plan has changed significantly from the approach approved by DHHS.

c. The Contractor shall:
    i. Participate in calls/meeting to discuss its Care Management Capacity Building program, upon request by the Department.
    ii. Provide additional documentation supporting the expenditures and distribution of funds to participating providers, within five (5) Business Days of the request by the Department.

d. The Department reserves the right to modify Capacity Building Distribution Plans to account for providers participating in multiple BH I/DD Tailored Plan's Tailored Care Management Capacity Building Performance Incentive Programs, in efforts to minimize duplicative investments.

e. Capacity Building Milestones
    i. The Department has identified the following six capacity building milestones to enhance HIT infrastructure, build the care manager workforce, and promote operational readiness:

Milestone 1	Submission of a detailed distribution plan that specifies the PIHP's approach (including quarterly targets) and proposed budget for meeting the remaining capacity building milestones, for Department approval.

	As long as the Capacity Building Distribution Plan clearly states that it applies to the BH I/DD Tailored Plan, the Capacity Building Distribution Plan may apply to other LME/MCO operations, including, without limitation, the PIHP.
Milestone 2	Submission of a Tailored Care Management training curriculum and conducting trainings for care managers employed by PIHP awardee and contracted AMH+ practices and CMAs
Milestone 3	Purchase or upgrades of care management related HIT infrastructure and systems for AMH+ practices and CMAs
Milestone 4	Hiring new care managers and supervisors at AMH+ practices and CMAs
Milestone 5	Completing Tailored Care Management training for AMH+ practices and CMAs' care managers and supervisors
Milestone 6	AMH+ practices/CMAs meeting other competencies linked to operationalizing Tailored Care Management (e.g., development of policies and procedures and education and outreach to members on the Tailored Care Management model)

ii. Sub-milestones and targets will be developed as part of the Distribution Plan, including sub-milestones targeted at supporting Historically Underutilized Providers. Capacity building funding is not intended to support PIHP, AMH+, and CMA needs in areas other than Tailored Care Management or that are not reflected in these milestones, sub-milestones, and targets.

iii. The PIHP shall not make the distribution of funds contingent on any milestone or requirement for providers that is not already defined in this Contract.

oo. ***Section IV. Scope of Services, L. Technical Specifications, 3. Enrollment and Reconciliation, c. Provider Enrollment and Credentialing, i., 2., ii.*** **is revised and restated in its entirety as follows:**

ii. Reserved.

pp. ***Section IV. Scope of Services, L. Technical Specifications, 3. Enrollment and Reconciliation, a. Member Enrollment and Reconciliation, i.*** **is revised to add the following:**

3. Prior to BH I/DD Tailored Plan launch, the PIHP shall have the ability to receive the current version of the 270 Eligibility Request File and send the current version of the 271 Eligibility Response File. This file should be real-time as well as include the ability to be submitted via the provider portal.

qq. ***Section IV. Scope of Services, L. Technical Specifications, 5. Provider Directory, b. Consolidated Provider Directory Data Transmissions, ii.*** **is revised and restated in its entirety as follows:**

ii. The PIHP shall create a successfully processed full Provider Network File (PNF) including data (as defined in the Contract) on all contracted and sub-contracted providers in their network. The PIHP shall deliver the file to the Department's designated vendor every Calendar Day by 5:00 PM EST. A successfully processed full PNF means that for each submission of the PNF by the PIHP to the Department's vendor, the PIHP has included all provider records from the

PIHP's network in the file submission and the PIHP receives a Provider Network Response File (PNRF) from the Department's vendor in response to the PNF submission.

rr. *Section IV. Scope of Services* is revised to add the following:

N. Transitions to Community Living

1. TCL Program Implementation
    a. The PIHP shall make available and implement all services and supports for members who are TCL members or TCL-eligible with the goal that individuals with disabilities have a right under the Rehabilitation Act, Americans with Disabilities Act, and the US Supreme Court decision in Olmstead v LC (1999), to receive community-based services that meet their needs in the most integrated setting possible. The PIHP shall ensure the availability and provision of services and supports for the TCL population it serves in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.
    b. To meet the terms of the Settlement Agreement, PIHP staff will continue to perform the TCL functions of in-reach, diversion, transition and complex care for TCL participants. PIHP TCL staff will work exclusively with TCL members or TCL-eligible individuals.
    c. The PIHP shall assign members eligible for TCL in-reach specialist, transition coordinator, registered nurse/occupational therapist evaluator team, and diversion specialist.
    d. The PIHP shall ensure that its registered nurses and occupational therapists or certified occupational therapist assistants (RN/OT Evaluator Team) provide physical health and functional assessments and transition planning assistance for all TCL members with complex medical conditions and/or significant functional deficits.
2. Tailored Care Management for TCL Members
    a. Tailored Care Management for TCL members provided by TCL Designated Tailored Care Management Providers and PIHP care managers shall incorporate all care coordination activities in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.
    b. Tailored Care Management for TCL members shall be performed by and be the responsibility of the PIHP as the assigned care manager, unless the TCL member elects to obtain Tailored Care Management from a TCL Designated Tailored Care Management Provider.
    c. TCL members and TCL-eligible individuals shall be assigned to Tailored Care Management based at the PIHP unless the member elects to obtain Tailored Care Management from a TCL Designated Tailored Care Management Provider in accordance with the provisions of this Section and *Section IV. G. 2.* . The PIHP shall ensure that TCL members and TCL-eligible individuals are afforded a choice of Tailored Care Management provider.
    d. Where applicable, the PIHP may allow an individual to continue receiving Tailored Care Management from their current provider where the provider is a TCL Designated Tailored Care Management Provider. PIHP TCL staff shall work cooperatively with TCL Designated Tailored Care Management providers and PIHP care managers to ensure that all care management and coordination needs of the TCL member or TCL-eligible

individual are effectively addressed. The PIHP shall ensure that all TCL functions are fulfilled for TCL members and TCL-eligible individuals who elect to receive Tailored Care Management from a TCL Designated Tailored Care Management Provider.

e. For TCL members who are receiving a duplicative TCM service, who opt out of Tailored Care Management, or who fail to engage in Tailored Care Management, the PIHP shall be responsible for performing care coordination in accordance with the requirements of the Settlement Agreement, the Department's TCL Implementation Plan.
f. The PIHP shall utilize the TCL-specific care management policy and TCL designation requirements developed by the Department to evaluate providers seeking to become a TCL Designated Tailored Care Management provider. The Department has selected NCQA as the organization responsible for certification of TCL Designated Tailored Care Management Providers.
g. The PIHP shall work cooperatively with NCQA and the Department to support qualified AMH+/CMA providers seeking to be designated by the Department to serve TCL members and TCL-eligible individuals in accordance with the TCL-specific Tailored Care Management requirements and process established by the Department. The PIHP shall establish and implement criteria for evaluation of qualified AMH+ practices and CMAs in accordance with the process developed by the Department and written guidance issued by the Department.
h. The PIHP shall submit to the Department a letter of support for those providers that have demonstrated experience effectively providing services to TCL members and TCL-eligible individuals and working effectively with TCL staff. PIHPs may work with Tailored Care Management providers by mutual agreement to prepare for NCQA pre-designation auditing. The letter shall include the PIHP's attestation that the provider meets the TCL designation requirements established by the Department and the support requirements established by the PIHP. The PIHP shall work cooperatively with the Department to ensure that all TCL Designated Tailored Care Management providers serving its members provide Tailored Care Management functions in accordance with the requirements of this Contract.
i. The PIHP shall notify the Department within five (5) Business Days after discovery if it learns that any TCL Designated Tailored Care Management Provider fails to continue meet the criteria established by the Department and the PIHP.
    i. Upon notification to the Department of any TCL Designated Tailored Care Management Provider failing to continue to meet the TCL Designated Tailored Care Management criteria established by the Department, if the Department determines that rescinding the provider's designation as a TCL Designated Tailored Care Management provider is appropriate, the Department will issue the provider and the PIHP written notice of its decision. The PIHP shall reassign any TCL Members receiving TCL Tailored Care Management services from the provider who has lost their designation as a TCL Designated Tailored Care Management provider and shall provide the Member notice of the reassignment within fourteen (14) Calendar Days after receipt of notice of the rescinded TCL designation from the Department.

ii. In the event the PIHP seeks to take action as permitted under its contract with the TCL Designated Tailored Care Management provider for failure to meet criteria for designation as a TCL Tailored Care Management provider or failure to perform as required under the provider contract, the PIHP shall notify the provider and issue appeal rights consistent with the provider contract.

j. The PIHP's TCL staff shall share the member's person-centered plan with the member's Tailored Care Management care manager.

k. The PIHP shall develop and implement an expedited process in order to receive and respond to inquiries from a plan based care manager , AMH+, or CMA delivering Tailored Care Management to the TCL member.
   i. For urgent situations affecting the TCL member's health, safety, and housing security, as determined in the PIHP's discretion, the PIHP shall respond to inquiries within twenty-four (24) hours of receiving them.
   ii. For non-urgent situations, the PIHP shall respond to inquiries within three (3) Business Days of receiving them.

l. The PIHP's TCL staff shall participate in any member care team meetings to which the PIHP's TCL staff have been invited by the Tailored Care Management care manager.

m. The PIHP shall ensure that the PIHP's TCL staff receive training on coordinating care with Tailored Care Management care managers.

3. Housing
   a. Development and Improvement of Housing Opportunities.
      i. The PIHP shall develop and implement strategies for accomplishing housing objectives and milestones for the TCL population in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan including the annual housing expectations as set for in *Section VI. Attachment X, Table 1: Annual Housing Expectations*. These housing objectives and milestones shall include without limitation:
         1. Reducing homelessness;
         2. Diverting individuals from institutional settings;
         3. Increasing the number of individuals entering supportive housing;
         4. Sustaining supportive housing and decreasing housing separations;
         5. Promoting independence for members with disabilities;
         6. Improving members' health;
         7. Helping members explore and obtain supported employment;
         8. Helping members sustain supported employment; and
         9. Increasing landlord engagement to increase the number of housing units available for Members.
      ii. The PIHP shall improve the capacity and performance of service providers to sustain supportive housing and improve housing retention rates in accordance with TCL Housing Guidelines issued by the Department and with the Department's TCL Implementation Plan.
      iii. The PIHP shall notify the Department of a housing separation that involves a Level 3 Incident or death of a TCL member within twenty-four (24) hours after the PIHP's discovery of the incident or death. The PIHP shall conduct a root cause analysis for housing separations that involve a Level 3 Incident or death of a TCL

member and report the findings of the root cause analysis to the Department within five (5) Business Days or other timeframe specified by the Department. The PIHP shall develop and implement any plan for performance improvement that may be required by the Department following any such housing separation within the timeframe specified by the Department. Any such performance improvement plan to be developed and implemented by the PIHP shall include without limitation, mitigation of any compliance and risk issues identified by the PIHP or the Department.

iv. Upon execution of this Amendment, the PIHP shall oversee the annual Housing Quality Inspections (HQS) which must be timely conducted by a third-party HQS certified housing inspector to ensure that each permanent supportive housing unit is safe, fully functional, and sanitary. PIHP may request approval from the Department to utilize HQS certified housing inspectors employed directly by the PIHP, subject to the Department's review of information presented by the PIHP, and in accordance with the following:

1. The PIHP shall submit to the Department on a monthly cadence a status report as to all required HQS inspections using the template provided by the Department.
2. The PIHP shall ensure timely completion of no less than ninety percent (90%) of HQS inspections in accordance with the Department's TCL Housing Guidelines. If, at any time, more than ten percent (10%) of the PIHP's required housing inspections are untimely, PIHP shall retain third-party certified housing inspectors to the extent needed to complete all pending and overdue inspections within thirty (30) Calendar Days.
3. The PIHP shall contract with the Housing Collaborative to conduct inspection of no less than five (5) of the PIHP's permanent supportive housing units each month. If inspections completed by the Housing Collaborative identify any noncompliant properties, the PIHP will have the opportunity to demonstrate that the issues causing the HQS inspection to fail occurred after completion of the most recent timely inspection by the PIHP.
4. If the Department determines that the PIHP has not sufficiently demonstrated that the cause of HQS inspection failure occurred after timely inspection by the PIHP, the PIHP will be required to contract with the Housing Collaborative at PIHP's expense, for re-inspection of any units that failed HQS inspection and retain a third-party certified inspector to verify no less than two percent (2%) of HQS inspections conducted by the PIHP-employed HQS-certified inspectors during the past six (6) months.
5. The Department may rescind the approval of the PIHP's use of PIHP-employed HQS-certified inspectors if the Housing Collaborative inspections reflect that fifteen percent (15%) or more of the PIHP housing inspections are not found to be safe, fully functional, and sanitary or if PIHP is unable to complete at least ninety percent (90%) of the housing inspections in a timely manner.

b. Housing Slots
   i. The PIHP shall provide supportive housing slots for TCL members to live in settings that meet the following criteria:
      1. They are permanent housing with Tenancy Rights;
      2. They include tenancy support services that enable members to attain and maintain integrated, affordable housing. Tenancy support services offered to members living in supportive housing are flexible and are available as needed and desired, but are not mandated as a condition of tenancy;
      3. They enable members with disabilities to interact with individuals without disabilities to the fullest extent possible;
      4. They do not limit a members ability to access community activities at times, frequencies and with persons of their choosing;
      5. They are scattered site housing, where no more than twenty percent (20%) of the units in any development are occupied by individuals with a disability known to the State, except as set forth below:
         a) Up to two hundred fifty (250) Housing Slots may be in disability-neutral developments, that have up to sixteen (16) units, where more than twenty percent (20%) of the units are occupied by individuals with a disability known to the State; and
         b) They afford individuals choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities.

c. In-Reach
   i. The PIHP shall ensure that preferences, recovery strategies, and goals documented in the In-Reach Transitions to Community Living (IR/TCL) tool are clearly documented in each TCL member's transition plan, which is the member's community services person-centered plan (PCP). For TCL members in a state psychiatric hospital (SPH), that information is required to be included in the member's SPH Continuing Care Plan (CCP).
   ii. TCL In-Reach and Diversion functions may not be delegated by PIHP or its TCL In-Reach or Diversion staff to any entity providing care management for the member.

d. Transition
   i. The PIHP shall convene, as frequently as needed, the transition teams supporting TCL members to effectively prepare a comprehensive discharge and transition plan for each TCL member. Transition team meetings shall occur in person and face-to-face with the TCL member.
   ii. The PIHP shall require the following to participate in meetings of transition teams supporting TCL members: (a) the TCL Transition Coordinator, (b) the Provider(s) that are or will be serving the TCL member; (c) where applicable, the member's care manager delivering tailored care management; and (d) in the case of transitions from state psychiatric facilities, the member's Social Worker.
   iii. PIHP transition team meetings supporting TCL members shall be led by the member and facilitated by the transition coordinator.
   iv. PIHP transition teams supporting TCL members shall complete the following responsibilities: (a) identify and specify services, service providers, and

community activities and supports required to meet the member's needs as part of the member's transition plan; and (b) establish tasks and timelines for transition team members to facilitate development of a comprehensive and timely discharge and transition plan.

v. PIHP staff with prior professional experience providing diversion, in-reach or transition services under the TCL program who do not meet the minimum credentials for "PIHP Transition Coordinator", "Outreach Diversion Specialist", or "Transition Supervisor" as defined in *Section VI. Second Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions* shall be permitted to fill the "PIHP Transition Coordinator", "Outreach Diversion Specialist", or "Transition Supervisor" role (as applicable) under the TCL program. TCL transition plan coordination for TCL members shall be the sole responsibility of the PIHP and its in-reach specialists, transition coordinators, diversion specialist, and their supervisors and associated PIHP staff.

vi. The PIHP shall address and resolve internally any obstacles to a TCL member's discharge and transition to community-based supportive housing. The PIHP shall resolve any barriers internally or refer any unresolved barriers to the Local Barriers Committee and for systemic barriers, the State Barriers Committee.

vii. The PIHP shall include all of the following personnel as standing members in local transition teams, also known as local barriers committees: (a) TCL leadership, (b) cross-functional representatives, (c) local Ombudsman, (d) DHHS TCL staff, and (e) ad hoc members such as individuals, providers, and other stakeholders.

viii. PIHP local barriers committees shall accomplish all of the following:

1. Meet at least monthly, and more often if needed to support the needs of TCL members;
2. Maintain an agenda that includes standing items, including without limitation, adult care home barriers, State barriers committee elevations, and Department state barriers committee updates; and
3. Keep minutes of each meeting and provide the Department with a copy of the local barriers committee meeting minutes for each month within seven (7) Business Days after the last day of the month.

ix. The PIHP shall ensure that no more than ninety (90) Calendar Days after a TCL participant transitions into supportive housing, the TCL Transition Coordinator convenes the member's transition team to assess and identify the member's ongoing needs and the transition team roles and responsibilities for meeting those needs.

x. The PIHP local barriers committee shall complete and submit to the Department its quarterly local barriers tracker or other local barriers committee activity logs requested by the Department.

e. Services

i. ACT Services

1. The PIHP shall ensure that for each TCL member in licensed facilities receiving ACT or CST services, the following will occur :
   a) The member must be fully informed of their rights and opportunities to transition into community-based permanent supportive housing,

employment/education, behavioral, medical, function skill and other services, and community integration activities in the community of their choice;

b) The member completes an Informed Decision-Making Tool (IDM) with their service provider, and the provider must file the completed IDM with the PIHP;

c) If the member chooses to transition, the provider will inform the PIHP's Care Manager and request that the Care Manager immediately initiate the in-reach and transition process and add all elements necessary for community transition to the member's Care Plan/ISP;

d) If more than six (6) months is needed for community transition, the PIHP shall require a reauthorization of ACT or CST for the member, and require as a prerequisite for reauthorization: (i) the reasons and barriers for transition contributing to the need for the service extension in the licensed facility, (ii) plans to overcome those barriers, and (iii) an update on the transition plan timeline to support the provider's reauthorization request.

ii. Assertive Engagement

1. The PIHP shall ensure that the community service providers are providing assertive engagement for members who are TCL members or TCL-eligible, and that assertive engagement services provided shall include all of the following:
   a) Engage and build rapport with members in the facility;
   b) Serve as standing and tasked members of transition teams supporting members;
   c) Complete assigned transition tasks before, during and after the member's transition; and
   d) Be available to directly assist the member in pre-transition community visitation.
2. The PIHP shall utilize funding provided by the Department to expand assertive engagement for the purpose of ensuring and improving access to assertive engagement for TCL members, including without limitation, to increase rates and/or improve payment models, and to ensure and improve the availability and provision of intensive services for TCL members in facilities.
3. The PIHP shall establish and implement provider contractual requirements for assertive engagement that are consistent with the Department's guidance regarding assertive engagement, and the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.

f. Quality Assurance and Performance Improvement

i. The PIHP shall include the following additional elements in its QAPI Plan to support its current and future TCL members in accordance with TCL QAPI Guidance issued by the Department:

1. Mechanisms to assess and validate the quality and sufficiency of services and supports provided to populations in or at risk of entrance into

institutional or adult care home settings, including member outcomes monitoring; and

2. Mechanisms to assess and validate the delivery, effectiveness and outcomes of contracted in-reach, discharge and transition planning, and pre-screening and diversion functions for populations in or at risk of entrance into institutional or adult care home settings.

g. Training Requirements for Staff and Providers
   i. The PIHP shall ensure that all of its staff (including without limitation In-Reach staff, Transition Coordinators, Diversion, and Tailored Care Management staff) and providers (including without limitation CST and ACT providers, and TCL Designated Tailored Care Management Providers) who support TCL members shall complete the following annual training curricula developed by the Department and made available by the Department free of charge on a virtual platform:
      1. Series of on-line housing training modules developed by TAC/ UNC that addresses service gaps identified in the coaching/mentoring of CST providers, tenancy rights, reasonable accommodations;
      2. Permanent Supportive Housing Refresher training; and
      3. DHHS-approved Person Centered Planning Training.
   ii. The PIHP shall develop and implement a barriers training curriculum specific to their region and the population they serve regarding local and state barriers identification, referrals, and solution processes in accordance with written guidance provided by the Department, including a template curriculum, and the Department's TCL Implementation Plan. The PIHP will submit the proposed training curriculum to the Department for approval within ninety (90) Calendar Days after the Department issues written guidance regarding the identification, referral and resolution of local and state barriers for the TCL population. The PIHP shall ensure that all staff (including without limitation In-Reach staff, Transition Coordinators, Diversion, and Tailored Care Management staff) and providers (including without limitation CST and ACT providers and TCL Designated Tailored Care Management Providers) who support TCL members complete this barriers training annually.

h. TCL Staffing Level
   i. To fulfill its responsibilities to serve and support TCL members and TCL-eligible individuals, the PIHP shall maintain the TCL staffing level needed to effectively serve the TCL members and TCL-eligible individuals in its Region in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.
   ii. The PIHP shall maintain a TCL team comprised of the appropriate number of the following key TCL positions needed to effectively serve PIHP's TCL members and TCL-eligible individuals:
      1. Transition Coordinator and Transition Coordinator Supervisor;
      2. In-Reach Specialist and In-Reach Supervisor;
      3. Outreach Diversion Specialist;
      4. Housing Development Coordinator;

5. Housing Supervisor;
6. Quality Assurance Specialist;
7. Data Analyst;
8. TCL Program Manager;
9. Supported Employment Specialist; and
10. Barriers and Training Coordinator.

i. Housing Pilot
   i. For PIHPs participating in the Department's TCL Housing Pilot, the PIHP shall maintain a TCL team comprised of the appropriate number of Transition Coordinators, In-reach Specialists, and Housing Development Specialists needed to implement the Department's TCL Housing Pilot in the PIHP's Region.

j. TCL Staff Expansion for Implementation Plan
   i. PIHP shall complete its responsibilities to serve TCL members and TCL-eligible individuals in accordance with the Settlement Agreement, the Department's TCL Implementation Plan, and the Department's TCL Housing Pilot (for participating PIHP's). The Department has identified key TCL staff positions that are required by each PIHP to serve TCL members and TCL-eligible individuals (collectively, "TCL Staff Expansion"). The Department shall notify each PIHP of its TCL Staff Expansion and the corresponding amount of TCL Staff Expansion Funding, as defined in the following paragraph.
   ii. The Department shall provide additional funds to the PIHP through the PIHP's PMPM for the sole purpose of helping to fund the additional expenses that will be incurred by the PIHP to hire and retain qualified individuals to fill the TCL Staff Expansion positions. PIHP shall use the TCL Staff Expansion Funding exclusively for the purpose of recruiting, hiring and retaining qualified individuals to fill the TCL Staff Expansion positions. To the extent needed to maintain an appropriate TCL staffing level to effectively serve TCL members and TCL-eligible individuals, the PIHP shall utilize funds available to it, including funds other than the TCL Staff Expansion Funding, for the purpose of hiring and retaining additional TCL staff beyond the specific positions funded by the TCL Staff Expansion Funding.
   iii. PIHP shall take all steps necessary to develop and implement expedited recruitment, hiring and onboarding of qualified individuals to fill the additional TCL Staff Expansion positions funded by the TCL Staff Expansion Funding. The PIHP shall leverage the experience and expertise of its existing TCL staff to support the hiring and onboarding of qualified individuals to fill the TCL Staff Expansion positions. PIHP shall complete the hiring and onboarding of all TCL Staff Expansion positions on or before November 30, 2023.

k. Department Monitoring of TCL Staff Expansion.
   i. To ensure the appropriate utilization of the Department's funding contribution toward each PIHP's TCL Staff Expansion, the Department will monitor the PIHP's recruiting, hiring, and onboarding practices for the TCL Staff Expansion positions to ensure the following:
      1. PIHP's job description aligns with the responsibilities for each type of position set forth in this Contract and written guidance issued by the Department;

2. New hiring salaries are competitively set using the TCL Staff Expansion Funding to reclassify current TCL positions, equitably blend and maintain new and current staff positions at all TCL staff levels;
3. The PIHP's expedited interview, hiring, PIHP onboarding, and TCL training ramp up meet the timelines established in this Contract;
4. The PIHP deploys TCL Staff Expansion positions; and
5. The PIHP continues to employ qualified individuals in the TCL Staff Expansion positions.

ii. Each PIHP shall submit quarterly reports to the Department regarding the status of its recruitment, hiring and onboarding of individuals for the TCL Staff Expansion positions within 15 days after the last day of each calendar quarter. For any PIHP that fails to comply with the timeline or other contractual requirements governing the TCL Staff Expansion, the Department may in its discretion perform onsite TCL Expansion Staff reviews to provide technical assistance and ongoing monitoring regarding the PIHP's progress with recruiting, hiring and onboarding individuals for the TCL Staff Expansion positions, and the PIHP's contract compliance with the terms of this Contract governing the TCL Staff Expansion.

IV. Modifications to Section V. Contract Performance

a. *Section V. Contract Performance, F. Payment of Liquidated Damages and other Monetary Sanctions, 1.* is revised and restated in its entirety as follows:

1. If the Contractor elects not to dispute the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within thirty-five (35) Calendar Days of the date of the written Notice of Deficiency assessing the liquidated damages or other monetary sanctions.

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

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

V. Modifications to Section VI. Attachments

Specific subsections are modified as stated herein.

a. *Section VI. First Revised and Restated Attachment A. Table 1. PIHP Organization Roles and Positions* is revised and restated as *Second Revised and Restated Attachment A. Table 1. PIHP Organization Roles and Positions* and is attached to this Amendment.

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

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

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

e. ***Section VI. Second Revised and Restated Attachment I. Reporting Requirements*** **is revised and restated as** *Section VI. Third Revised and Restated Attachment I. Reporting Requirements* and is attached to this Amendment.

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

g. ***Section*** **VI.** ***First Revised and Restated Attachment L. Policies, 4. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*** **is revised and restated as** *Second Revised and Restated Attachment L. Policies, 4. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards* and is attached to this Amendment.

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

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

j. ***Section VI. Attachment P. PIHP Capitation Rates*** is attached to this Amendment.

k. ***Section VI.*** **is revised to add** ***Attachment X. Annual Housing Expectations*** and is attached to this Amendment.

VI. Effective Date

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

VII. Other Requirements

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

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

Department of Health and Human Services

_____ Date: _____
Jay Ludlam, Deputy Secretary

PIHP Name

_____ Date: _____
PIHP Authorized Signature

Second 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. Second 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.

Section VI. Second 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**

		• 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:
		  ○ 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).
		  ○ 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

Section VI. Second 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**
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 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.

Section VI. Second 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**
		• 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.
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

Section VI. Second 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**
		○ a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or ○ 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.
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.

Section VI. Second 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**
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.
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	• Must meet North Carolina Residency requirements.

Section VI. Second 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**
	contact to triage and escalate member specific or PIHP questions.	
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 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	• 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. Second 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**
	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	• 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. Second 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**
	transition planning, quality of 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	

Section VI. Second 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**
	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;. 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.	• 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.
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;	• 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

Section VI. Second 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. 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) 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	and Supports (IPS), Vocational Rehabilitation, or other research-based employment model).

Section VI. Second 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**
	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: 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	• Must meet North Carolina Residency Requirements • Must be a North Carolina Certified Peer Support Specialist (NC CPSS)

Section VI. Second 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**
	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.

Section VI. Second 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 a 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 the NC Medicaid Managed Care Technical Specifications document 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 *Second Revised and Restated Section VII. Attachment D.* (e.g., for updates to the quality metrics posted in January 2023, the PIHP would report the results in June 2024).

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. Second 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.

Section VI. Second Revised and Restated Attachment D. Table 1: Survey Measures and General Measures: Pediatric						
Ref #	**NQF #**	**Measure Name**		**Steward**	**Measurement Period**	**Submission**
4.	0108	Follow-up for Children Prescribed ADHD Medication	NCQA	Annually Calendar Year	June 1	
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1	
9.	2801	Use of Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1	
10	N/A	Total Eligible Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	NC DHHS	Annually Calendar Year	June 1	

The Remainder of this page is intentionally left blank.

Section VI. Second Revised and Restated Attachment D. Table 2: Survey Measures and General Measures: Adult					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA	Annually Calendar Year	June 1
6.	3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC	Annually Calendar Year	June 1
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	Annually Calendar Year	June 1
10.	0576	Follow-up After Hospitalization for Mental Illness	NCQA	Annually Calendar Year	June 1
16.	NA	Rate of Screening for Unmet Resource Needs	NC DHHS	Annually Calendar Year	June 1

Section VI. Second Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Proportion of Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
5.	Proportion of New Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Second Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of (c) waiver providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			
14.	Percentage of beneficiaries reporting that their Individual Support Plans has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
16.	Proportion of ISPs in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1

Section VI. Second Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
17.	Proportion of individuals whose annual Individual Support Plans was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
18.	Proportion of individuals for whom an annual ISP took place.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
19.	Number and percentage of waiver participants whose Individual Support Plans were revised, as applicable, by the Care Coordinator to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Reserved.			
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within forty-five (45) Calendar Days of ISP approval.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
22.	Proportion of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1

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

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

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

Section VI. Second 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 SMI/SED who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
4.	Number of PIHP members with SUD who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
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

Section VI. Second Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures					
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**	
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.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11	
19.	Percentage of beneficiaries reporting that their Care Plan/ISP has the services that they need.	NC DHHS	Annually Fiscal Year	November 1	
20.	Proportion of Care Plan/ISPs that address identified health and safety risk factors.		NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
21.	Proportion of Care Plans/ISPs in which the services and supports reflect beneficiary assessed needs and life goals.		NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of individuals whose annual Care Plan/ISP was revised or updated.		NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
23.	Proportion of individuals for whom an annual Care Plan/ISP took place.		NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

Section VI. Second Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures					
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**	
24.	Number and percentage of PIHP members using 1915(i) services whose Care Plans/ISPs were revised, as applicable, by the Care Manager to address their changing needs.		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
25.	Proportion of beneficiaries who are using 1915(i) services in the type, scope, amount, and frequency as specified in the Care Plan/ISP.		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
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP within 45 days of ISP approval.		NC DHHS	Annually Fiscal Year	November 1
27.	Proportion of records that contain a signed freedom of choice statement.		NC DHHS	Annually Fiscal Year	November 1
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

Section VI. Second Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures					
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**	
30.	Number and percentage of beneficiary deaths of PIHP members using 1915(i) services where required BH I/DD Tailored Plan follow-up interventions were completed 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
31.	Number and percent of actions taken to protect the beneficiary using 1915(i) services, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.		NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
32.	Percentage of PIHP members using 1915(i) services who received appropriate medication.		NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VI. Second Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures					
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**	
33.	Percentage of medication errors resulting in medical treatment for PIHP members using 1915(i) services.		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
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

Section VI. Second Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures					
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**	
37.	Number and percentage of level 2 or 3 incidents where required PIHP follow-up interventions were completed 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
38.	Percentage of level 2 and 3 incidents reported within required timeframes.		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
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

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

Section VI. Second Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures					
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**	
45.	The percentage of continuously enrolled PIHP members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.		NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
46.	The percentage of continuously enrolled PIHP members using 1915(i) services ages twenty (20) and older who received a primary care or preventative health service during the measurement period.		NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

The remainder of this page is intentionally left blank.

Section VI. Second 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.

More background information is available at the following link, accurate as of October 1, 2023

https://webservices.ncleg.gov/ViewDocSiteFile/34158

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

Section VI. Second Revised and Restated Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		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	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
3.	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: o 2+ facilities within each PIHP Region, OR o 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 (social setting detoxification), Mobile Crisis Management:* ≥ 1 provider of each crisis service within each PIHP Region • *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	
4.	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP region	
5	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
6	Community/ Mobile Services	≥ 2 providers of community/mobile services within each PIHP Region. Each county in PIHP Region must have access to ≥ 1 provider that is accepting new patients.	
7	Reserved.		
8	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per PIHP Region • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment)*:* Access to ≥ 1 licensed provider per PIHP Region *(refer to 10A NCAC 27G.3400)* • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): o *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) o *Adolescent:* Contract with all designated CASPs statewide o *Women & Children:* Contract with all designated CASPs statewide • Clinically Managed Population-Specific High Intensity Residential Program: contract with all designated CASPs	

Section VI. Second Revised and Restated Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house: ○ *Adult:* Access to ≥1 male and ≥1 female program per PIHP Region (Refer to 10A NCAC 27G .5600)8 ○ *Adolescent:* Access to ≥ 1 program per PIHP Region (refer to 10A NCAC 27G.5600) • Psychiatric *Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard	
9	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each PIHP Region* • *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each PIHP Region* • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard*	
10	1915(i) Services	• *Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) service within each PIHP Region* • *In-Home Respite: ≥ 2 providers within 45 minutes of the member's residence.*	
11	All State Plan LTSS (except nursing facilities and 1915(i) services)*	• ≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county	
12	Employment and Housing Services	• *Individual Placement and Supports (IPS) – Supported Employment (Adult MH):* Eligible individuals shall have the choice of at least two (2) provider agencies within each PIHP Region. Each county in PIHP Region must have access to ≥1 provider that is accepting new patients	

Section VI. Second 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 • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification) • Ambulatory withdrawal management with extended on-site monitoring • Clinically managed residential withdrawal services (social setting detoxification) • Medically monitored inpatient withdrawal services (Nonhospital medical detoxification) (adult) • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult) • Mobile Crisis Management
4.	Inpatient BH Services	• *Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Medically managed intensive inpatient withdrawal management (Acute care hospitals with adult inpatient substance use beds) • Medically managed intensive inpatient services (Acute care hospitals with adult inpatient substance use beds) • Inpatient Hospital – Adolescent / Children • Acute care hospitals with adolescent inpatient psychiatric beds • Medically managed intensive inpatient services (Acute care hospitals with adolescent inpatient substance use beds) • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial Hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment facility services • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment):

Section VI. Second Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
		• Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): • Clinically Managed Population-Specific High Intensity Residential Program • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house): • Psychiatric Residential Treatment Facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
7.	Community/Mobile Services	• Assertive Community Treatment (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports • Diagnostic Assessment
8.	1915(i) HCBS	• Supported Employment • Individual Support • Respite • Community Living and Support • Community Transition
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. Second 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 First 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. ~~First~~ 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. First 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 SUD	Refer to *Section VI. Attachment L.4. First 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. First 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. First 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. First 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. First Revised and Restated BH Service Classifications for Appointment Wait*	Within forty-eight (48) hours

Section VI. Second Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Service Type**	**Definition**	**Standard**
		Time and Routine, Urgent and Emergent Care Standards	

The remainder of this page is intentionally left blank.

Section VI. Second 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 in which the provider must notify the PIHP 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 member'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.

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.

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 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 [Company] for processing and payments within one-hundred-eighty (180) Calendar Days from the date of covered service or discharge (whichever is later). The [Provider] shall submit all claims with a date of service on or after BH I/DD Tailored Plan Launch, to the [Company] for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

For Medical claims (including behavioral health):

1. The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim. The 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 April 1, 2024, or a later date if approved by the Department.

2. The [Company] shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the Claim or the first scheduled provider reimbursement cycle following adjudication.
3. Reserved.
4. Reserved.
5. Reserved.
6. Reserved.
7. Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] penalties equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.
8. The [Company] shall pay the interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to request the interest or the liquidated damages.

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 July 1, 2024, contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial

tobacco-free policy. In these settings, the following policies shall be required:

[Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

1. Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee
2. Outdoor areas of the property under, [PROVIDER'S] control as owner or lessee shall:
    a. Ensure access to common outdoor space(s) free from exposure to tobacco use; and.
    b. Prohibit staff/employees from using tobacco products anywhere on the property.

Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

iii. Providers subject to Full Tobacco-Free Policy

Starting July 1, 2024, 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.*

The remainder of this page is intentionally left blank.

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

Section VI. Third Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
3. PIHP Enrollment Summary Report	Monthly summary report highlighting key member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid eligibility category, number of Member welcome packets sent, and time to distribute Member welcome packets.	Monthly
4. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
5. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
C. Benefits		
1. Institute of Mental Disease (IMD) Report	Bi-Weekly summary of Members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, 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 PMs are required to demonstrated compliance with 1915(c) waiver assurances.	Quarterly
8. TBI Performance Measures Report	Quarterly/semi-annual/annual PMs are required to demonstrated compliance with 1915(c) waiver assurances.	Quarterly
9. 1915(i) Performance Measures Report	This report is to demonstrate ongoing compliance with annual/semi-annual/quarterly 1915(i) state plan performance measures.	Quarterly

Section VI. Third Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
10. Emergency Department Boarding for Children in Medicaid	Weekly report of all children under age 18 who are boarding in an Emergency Department awaiting medically necessary treatment for Behavioral Health, IDD, or TBI. For any child in the ED over 7 days, document escalation to 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 information for, including but not limited to, individuals with SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) system.	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.	Bi-Annually
14. Service Associated Request Report	PIHPs decision regarding the service requested on the Request to Move: Provider Form.	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.	Quarterly
2. Reserved.		
3. TCM Provider Status Change Report	Monthly reporting on tracking TCM provider status changes and the associated decision reasoning.	Monthly
4. TCM Provider Contracting and Integration Report	Weekly TCM Provider contracting and integration status report.	Weekly
E. In-Reach and Transitions		
1. IDD In Reach, Diversion, Transition Activity Report		Quarterly
2. SED In Reach, Diversion, Transition Activity Report	This report is for SED members related to: <u>In Reach:</u> Number and percentage of members who are referred for or request placement in an institutional setting	Quarterly

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

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

Section VI. Third Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
8. Capitation Reconciliation Report	Monthly report to inform the State of any capitation-related payment discrepancies observed. PIHPs will include records of members where no payment was received from the State or payment received differed from the amount expected. PIHPs will only include member records with discrepancies on this report to the State. The PIHP Capitation Reconciliation Report will be submitted on a monthly cadence. PIHPs will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
9. Reserved		
10. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Quarterly
11. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
12. Reserved.		
G. Quality and Value		
1. QAPI Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
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

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

Section VI. Third Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	**PIHP Report Description**	**Frequency**
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*	Weekly summary of BH claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional or, institutional. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period. Note: Ad-hoc upon request. Ad hoc report will be requested no less than ten (10) Calendar Days in advance or mutually agreed upon timeframe *For BH claims only	Weekly
4. Payer Initiated Claim Adjustment Report	Ad hoc report required in the event the State deems necessary or a provider escalates grievance related to PIHP claim adjustment processing. The PIHP must complete required information within the report for the Department to validate appropriate claim adjustment was complete.	Ad hoc

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

Section VI. Third Revised and Restated Attachment I. Table 3: PIHP Reporting Requirements for Healthy Opportunities Pilot (Required Only for PIHPs Participating in the Pilot)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
1. Healthy Opportunities Pilot Key Metrics Report	Report of Healthy Opportunities Pilot key metrics, including at a minimum: Members served, services used, total service delivery costs, and Member cost and utilization metrics related to the Healthy Opportunities Pilot.	Quarterly
2. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PIHP may submit if the Department notifies the PIHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PIHP's anticipated spending through the remainder of the Pilot service delivery year.	Optional, or at the discretion of the PIHP
3. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly report of PIHP Pilot service delivery spending.	Monthly
4. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PIHP Pilot administrative fund spending.	Quarterly
5. Healthy Opportunities Pilot Care Management Payment Report	Monthly report of PIHP spending on care management payments. The Department will provide the PIHP with at least sixty (60) Calendar Days' notice before this report is due, which will be determined when the first AMH+(s)/CMA(s) begin participating in the Healthy Opportunities Pilot.	Monthly

The remainder of this page is intentionally left blank.

Section VI. Attachment L. Policies. 3. Second Revised and Restated Uniform Credentialing and Re-credentialing Policy for Medicaid and NC Health Choice Providers

a. Background

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

b. Scope

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

c. Policy Statement

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

d. Centralized Provider Enrollment and Credentialing

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

credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).

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

e. Provider Credentialing and Re-credentialing Policy

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

license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

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

Section VI. Attachment L. Policies. 4. Second 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. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.

x. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.

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.

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

1) Background

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

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

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

2) Scope

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

3) Policy Statement

The PIHP shall implement:

a) Claim Submission

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

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

b) Payment

i) PIHP shall comply with PIHP Contract Section V.D.4.h., *Indian Health Care Provider (IHCP) Payments*

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

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

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

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

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

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

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

c) Prompt Pay

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

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

(a) Claims

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

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

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

(2) The PIHP shall reprocess claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).

(3) 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.

(4) Interest and Penalties

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

(b) In addition to the interest on late payments required by this Section, the PIHP shall pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.

(c) The PIHP shall not be subject to interest or penalty payments if its failure to comply is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the PIHP's reasonable control, including an act of God, insurrection, strike, fire, or power outages. Also, the PIHP is not subject to interest or penalty payments

if the PIHP has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

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

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

d) Other Payment Sources

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

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

e) Sovereignty

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

The remainder of this page is intentionally left blank.

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

Table 1: Liquidated Damages for Compliance Issues

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

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

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

Section VI. Third Revised and Restated Attachment N: Table 1: Liquidated Damages (January 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure to report notice of provider termination from participation in the PIHP's provider network (includes terminations initiated by the provider or by the PIHP) to the Department or to the affected Members within the timeframes required by *Section IV.H.2. Provider Network Management.*	$25 per Calendar Day per Member for failure to timely notify the affected member or Department
3.	Reserved.	[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]
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 PHP 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. Third Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day

Section VI. Third Revised and Restated Attachment N: Table 1: Liquidated Damages (January 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VI. Third 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. Third 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. Third Revised and Restated Attachment I. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$250 per Calendar Day
I. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section IV.C. Compliance.*	$1,250 per Calendar Day that Department determines PIHP is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section IV.C. Compliance and Section VI. Third Revised and Restated Attachment I. Reporting Requirements.*	$250 per Calendar Day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section IV.C.4. Third Party Liability (TPL) and Section VI. Third 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. Third Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day
J. Technical Specifications		
1.	Failure by the PIHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$125 per Member per occurrence

Section VI. Third Revised and Restated Attachment N: Table 1: Liquidated Damages (January 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure by the PIHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$125 per occurrence
3.	Failure by the PIHP to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	$125 per Member per occurrence, not to exceed $2,500,000
K. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$125 per Calendar Day
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$250 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$125 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g., drug utilization review program).	$ 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. Third Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (January 1,, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The PIHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PIHP to its system to trigger enrollment and disenrollment processes.	Daily	$250 per twenty-four (24) hour period Note: Effective one (1) month prior to Medicaid Direct PIHP launch.
2.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the PIHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	The PIHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the PIHP within the required timeframe divided by the total number of new Members enrolled in the PIHP during the measurement period.	Monthly	98.99% - 95%:$1,250 per month 94.99% - 80%: $1,875 per month 79.99% or less: $2,500 per month
3.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the PIHP utilizes separate mailings to send*	The PIHP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the PIHP within the required timeframe divided by the total number of new Members enrolled in the PIHP during	Monthly	98.99% - 95%: $1,250 per month 94.99% - 80%: $1,875 per month 79.99% or less: $2,500 per month

Section VI. Third Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (January 1,, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	components of the Welcome Packet		the measurement period.		
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	$2,500 per month

Section VI. Third Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (January 1,, 2024)					
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	$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	$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 AMH+ practices and CMAs.	Monthly	$12,500 per month

Section VI. Third Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (January 1,, 2024)					
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.	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.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$6,250 per month
3.	Encounter Data Reconciliation-	The encounters submitted by the PIHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PIHP.	Monthly	$2,500 per month

Section VI. Third Revised and Restated Attachment N. Table 3: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot) (January 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
1	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements.	$125 per Calendar Day that the Department determines the PIHP is not in compliance
2	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes.	$125 per Calendar Day
3	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes.	$125 per Calendar Day
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

Section VI. P. PIHP Capitation Rates

Attachment P: MEDICAID PAYMENT AMOUNTS

Alliance Medicaid Capitation Rates

July 1, 2023 – November 30, 2023

CAPITATION RATES (Total Rate)

Rating Group	Ages	July - November 2023 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.27
Standard Plan, ABD	All Ages	$ 30.93
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 596.43
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 950.59
BH I/DD Tailored Plan, ABD	21+	$ 1,253.60
Innovations	All Ages	$ 8,935.78
Foster Children	All Ages	$ 801.78
Other	All Ages	$ 6.87
TBI	22+	$ 7,281.84

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	91.6%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Alliance Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Alliance Health Management Medicaid Capitation Rates

December 1, 2023 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.27
Standard Plan, ABD	All Ages	$ 30.94
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 596.52
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 950.73
BH I/DD Tailored Plan, ABD	21+	$ 1,253.78
Innovations	All Ages	$ 8,937.07
Foster Children	All Ages	$ 801.90
Other	All Ages	$ 6.87
TBI	22+	$ 7,282.89
Standard Plan, Newly Eligible	19-64	$ 18.91
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 444.91

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	91.6%
Total Across Expansion Rating Groups	19-64	91.6%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Alliance Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Alliance Medicaid Capitation Rates

January 1, 2024 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.57
Standard Plan, ABD	All Ages	$ 35.66
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 642.12
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 1,024.33
BH I/DD Tailored Plan, ABD	21+	$ 1,305.53
Innovations	All Ages	$ 8,917.78
Foster Children	All Ages	$ 857.31
Other	All Ages	$ 8.45
TBI	22+	$ 8,192.57
Standard Plan, Newly Eligible	19-64	$ 21.47
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 481.41

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	91.8%
Total Across Expansion Rating Groups	19-64	91.9%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Alliance Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Eastpointe Medicaid Capitation Rates

July 1, 2023 – November 30, 2023

CAPITATION RATES (Total Rate)

Rating Group	Ages	July - November 2023 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 7.04
Standard Plan, ABD	All Ages	$ 20.06
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 488.73
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 847.23
BH I/DD Tailored Plan, ABD	21+	$ 1,140.57
Innovations	All Ages	$ 8,776.65
Foster Children	All Ages	$ 702.77
Other	All Ages	$ 3.97

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	88.9%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Eastpointe Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Eastpointe Health Management Medicaid Capitation Rates

December 1, 2023 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 7.04
Standard Plan, ABD	All Ages	$ 20.04
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 488.27
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 846.42
BH I/DD Tailored Plan, ABD	21+	$ 1,139.49
Innovations	All Ages	$ 8,767.94
Foster Children	All Ages	$ 702.09
Other	All Ages	$ 3.96
Standard Plan, Newly Eligible	19-64	$ 13.51
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 471.61

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	89.0%
Total Across Expansion Rating Groups	19-64	89.1%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Eastpointe Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Eastpointe Medicaid Capitation Rates

January 1, 2024 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 7.36
Standard Plan, ABD	All Ages	$ 23.50
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 518.25
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 898.55
BH I/DD Tailored Plan, ABD	21+	$ 1,164.44
Innovations	All Ages	$ 8,748.47
Foster Children	All Ages	$ 754.50
Other	All Ages	$ 4.23
Standard Plan, Newly Eligible	19-64	$ 14.91
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 493.80

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	89.2%
Total Across Expansion Rating Groups	19-64	89.4%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Eastpointe Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Partners Health Management Medicaid Capitation Rates

July 1, 2023 – November 30, 2023

CAPITATION RATES (Total Rate)

Rating Group	Ages	July - November 2023 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.18
Standard Plan, ABD	All Ages	$ 28.72
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 503.65
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 813.56
BH I/DD Tailored Plan, ABD	21+	$ 1,278.91
Innovations	All Ages	$ 7,990.70
Foster Children	All Ages	$ 681.28
Other	All Ages	$ 5.97

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	90.0%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Partners Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Partners Health Management Medicaid Capitation Rates

December 1, 2023 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.18
Standard Plan, ABD	All Ages	$ 28.73
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 503.93
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 814.02
BH I/DD Tailored Plan, ABD	21+	$ 1,279.62
Innovations	All Ages	$ 7,995.31
Foster Children	All Ages	$ 681.67
Other	All Ages	$ 5.97
Standard Plan, Newly Eligible	19-64	$ 18.23
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 365.43

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	89.9%
Total Across Expansion Rating Groups	19-64	90.1%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Partners Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Partners Health Management Medicaid Capitation Rates

January 1, 2024 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.92
Standard Plan, ABD	All Ages	$ 31.85
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 557.99
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 907.70
BH I/DD Tailored Plan, ABD	21+	$ 1,321.43
Innovations	All Ages	$ 7,968.65
Foster Children	All Ages	$ 735.73
Other	All Ages	$ 6.82
Standard Plan, Newly Eligible	19-64	$ 21.47
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 418.79

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	90.3%
Total Across Expansion Rating Groups	19-64	90.4%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Partners Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Sandhills Center Resources Medicaid Capitation Rates

July 1, 2023 – November 30, 2023

CAPITATION RATES (Total Rate)

Rating Group	Ages	July - November 2023 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 10.25
Standard Plan, ABD	All Ages	$ 24.98
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 460.03
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 762.42
BH I/DD Tailored Plan, ABD	21+	$ 1,089.69
Innovations	All Ages	$ 10,095.52
Foster Children	All Ages	$ 578.38
Other	All Ages	$ 3.84

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	91.8%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Sandhills Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Sandhills Health Management Medicaid Capitation Rates

December 1, 2023 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 10.25
Standard Plan, ABD	All Ages	$ 24.98
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 459.91
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 762.21
BH I/DD Tailored Plan, ABD	21+	$ 1,089.39
Innovations	All Ages	$ 10,092.69
Foster Children	All Ages	$ 578.21
Other	All Ages	$ 3.84
Standard Plan, Newly Eligible	19-64	$ 17.06
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 440.11

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	91.9%
Total Across Expansion Rating Groups	19-64	92.0%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Sandhills Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Sandhills Center Resources Medicaid Capitation Rates

January 1, 2024 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 10.84
Standard Plan, ABD	All Ages	$ 28.20
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 490.49
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 823.49
BH I/DD Tailored Plan, ABD	21+	$ 1,112.91
Innovations	All Ages	$ 10,076.63
Foster Children	All Ages	$ 607.05
Other	All Ages	$ 4.48
Standard Plan, Newly Eligible	19-64	$ 18.74
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 467.83

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	92.0%
Total Across Expansion Rating Groups	19-64	92.1%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Sandhills Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Trillium Health Resources Medicaid Capitation Rates

July 1, 2023 – November 30, 2023

CAPITATION RATES (Total Rate)

Rating Group	Ages	July - November 2023 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 9.42
Standard Plan, ABD	All Ages	$ 25.71
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 553.23
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 842.90
BH I/DD Tailored Plan, ABD	21+	$ 1,327.90
Innovations	All Ages	$ 8,738.15
Foster Children	All Ages	$ 668.26
Other	All Ages	$ 5.12

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	91.4%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Trillium Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Trillium Health Management Medicaid Capitation Rates

December 1, 2023 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 9.42
Standard Plan, ABD	All Ages	$ 25.72
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 553.31
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 843.03
BH I/DD Tailored Plan, ABD	21+	$ 1,328.10
Innovations	All Ages	$ 8,739.50
Foster Children	All Ages	$ 668.36
Other	All Ages	$ 5.12
Standard Plan, Newly Eligible	19-64	$ 15.43
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 386.68

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	91.4%
Total Across Expansion Rating Groups	19-64	91.5%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Trillium Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Trillium Health Resources Medicaid Capitation Rates

January 1, 2024 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 11.07
Standard Plan, ABD	All Ages	$ 33.40
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 601.55
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 921.79
BH I/DD Tailored Plan, ABD	21+	$ 1,359.33
Innovations	All Ages	$ 8,722.37
Foster Children	All Ages	$ 740.65
Other	All Ages	$ 6.19
Standard Plan, Newly Eligible	19-64	$ 18.13
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 422.58

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	91.6%
Total Across Expansion Rating Groups	19-64	91.7%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Trillium Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Vaya Health Medicaid Capitation Rates

July 1, 2023 – November 30, 2023

CAPITATION RATES (Total Rate)

Rating Group	Ages	July - November 2023 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 14.46
Standard Plan, ABD	All Ages	$ 40.49
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 628.47
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 867.07
BH I/DD Tailored Plan, ABD	21+	$ 1,300.02
Innovations	All Ages	$ 7,968.44
Foster Children	All Ages	$ 695.02
Other	All Ages	$ 10.75

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	89.3%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	July - November 2023 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Vaya Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Vaya Health Management Medicaid Capitation Rates

December 1, 2023 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 14.45
Standard Plan, ABD	All Ages	$ 40.46
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 628.10
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 866.55
BH I/DD Tailored Plan, ABD	21+	$ 1,299.25
Innovations	All Ages	$ 7,963.59
Foster Children	All Ages	$ 694.60
Other	All Ages	$ 10.75
Standard Plan, Newly Eligible	19-64	$ 26.15
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 488.74

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	89.3%
Total Across Expansion Rating Groups	19-64	89.5%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	December 2023 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Vaya Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Attachment P: MEDICAID PAYMENT AMOUNTS

Vaya Health Medicaid Capitation Rates

January 1, 2024 – June 30, 2024

CAPITATION RATES (Total Rate)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Standard Plan, Non-ABD	All Ages	$ 16.21
Standard Plan, ABD	All Ages	$ 47.82
BH I/DD Tailored Plan, Non-ABD	All Ages	$ 672.81
BH I/DD Tailored Plan, Blind/Disabled	0 - 20	$ 930.97
BH I/DD Tailored Plan, ABD	21+	$ 1,337.97
Innovations	All Ages	$ 7,939.02
Foster Children	All Ages	$ 751.49
Other	All Ages	$ 13.29
Standard Plan, Newly Eligible	19-64	$ 30.52
BH I/DD Tailored Plan, Newly Eligible	19-64	$ 529.60

CAPITATION RATES (Risk Corridor Target Treatment Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across Non-Expansion Rating Groups	All Ages	89.7%
Total Across Expansion Rating Groups	19-64	89.8%

CAPITATION RATES (Minimum Medical Loss Ratio)

Rating Group	Ages	January 2024 - June 2024 Contract Rates
Total Across All Rating Groups	All Ages	85.0%

Vaya Representative **Approved/Accepted** _____ **Date** _____

DHHS Representative **Approved/Accepted** _____ **Date** _____

CMS Representative **Approved/Accepted** _____ **Date** _____

Section VI. Attachment X: Annual Housing Expectations

The DOJ Settlement Agreement (SA) specified the number of individuals expected to transition into the community within five population categories. The Department devised an annual transition expectation method to fairly distribute the numbers required to meet substantial compliance. As of the fifth SA extension, six hundred (600) more individuals must transition out of ACHs by June 30, 2025. The Contractor transition expectation apportioning method equally divides the first half of six hundred (600) expected transitions. The second half of the six hundred (600) transitions are apportioned to each Contractor based on their percentage of Medicaid covered lives. Quarterly DHHS monitoring keeps pace with each Contractor to both ensure transition expectation progress, early identification of transition barriers, and associated quarterly Contractor incentive plan payouts.

Section VI. Attachment X: Annual Housing Expectations*								
LME/MCO	Pop Served	SFY 21 / SFY 22 (2nd half of year) Jan 22 - June 22	SFY 22 / SFY 23	SFY 22 / SFY 23 Quarterly Expectations	SFY 23 / SFY 24 (1st half divided equally)	SFY 23 / SFY24 (2nd half based on pop served)	SFY 23 / SFY 24 Net Year End Total	SFY 23 / SFY 24 Quarterly Expectations
Alliance	34%	55	110	27	50	102	152	38

*Model used for SFY 23 / SFY 24 - First half of the six hundred (600) individuals housed (300) is split among the BH I/DD Tailored Plans and PIHP with the second three hundred (300) individuals based on the percentage of the population served by the BH I/DD Tailored Plan and PIHP. The Department is planning for six hundred (600) net transitions each year for the next two (2) years.

Section VI. Attachment X: Annual Housing Expectations*								
LME/MCO	Pop Served	SFY 21 / SFY 22 (2nd half of year) Jan 22 - June 22	SFY 22 / SFY 23	SFY 22 / SFY 23 Quarterly Expectations	SFY 23 / SFY 24 (1st half divided equally)	SFY 23 / SFY24 (2nd half based on pop served)	SFY 23 / SFY 24 Net Year End Total	SFY 23 / SFY 24 Quarterly Expectations
Eastpointe	6%	11	21	6	50	18	68	17

*Model used for SFY 23 / SFY 24 - First half of the six hundred (600) individuals housed (300) is split among the BH I/DD Tailored Plans and PIHP with the second three hundred (300) individuals based on the percentage of the population served by the BH I/DD Tailored Plan and PIHP. The Department is planning for six hundred (600) net transitions each year for the next two (2) years.

Section VI. Attachment X: Annual Housing Expectations*								
LME/MCO	Pop Served	SFY 21 / SFY 22 (2nd half of year) Jan 22 - June 22	SFY 22 / SFY 23	SFY 22 / SFY 23 Quarterly Expectations	SFY 23 / SFY 24 (1st half divided equally)	SFY 23 / SFY24 (2nd half based on pop served)	SFY 23 / SFY 24 Net Year End Total	SFY 23 / SFY 24 Quarterly Expectations
Partners	15%	31	62	16	50	45	95	24

*Model used for SFY 23 / SFY 24 - First half of the six hundred (600) individuals housed (300) is split among the BH I/DD Tailored Plans and PIHP with the second three hundred (300) individuals based on the percentage of the population served by the BH I/DD Tailored Plan and PIHP. The Department is planning for six hundred (600) net transitions each year for the next two (2) years.

Section VI. Attachment X: Annual Housing Expectations*								
LME/MCO	Pop Served	SFY 21 / SFY 22 (2nd half of year) Jan 22 - June 22	SFY 22 / SFY 23	SFY 22 / SFY 23 Quarterly Expectations	SFY 23 / SFY 24 (1st half divided equally)	SFY 23 / SFY24 (2nd half based on pop served)	SFY 23 / SFY 24 Net Year End Total	SFY 23 / SFY 24 Quarterly Expectations
Sandhills	12%	23	47	12	50	36	86	22

*Model used for SFY 23 / SFY 24 - First half of the six hundred (600) individuals housed (300) is split among the BH I/DD Tailored Plans and PIHP with the second three hundred (300) individuals based on the percentage of the population served by the BH I/DD Tailored Plan and PIHP. The Department is planning for six hundred (600) net transitions each year for the next two (2) years.

Section VI. Attachment X: Annual Housing Expectations*								
LME/MCO	Pop Served	SFY 21 / SFY 22 (2nd half of year) Jan 22 - June 22	SFY 22 / SFY 23	SFY 22 / SFY 23 Quarterly Expectations	SFY 23 / SFY 24 (1st half divided equally)	SFY 23 / SFY24 (2nd half based on pop served)	SFY 23 / SFY 24 Net Year End Total	SFY 23 / SFY 24 Quarterly Expectations
Trillium	15%	25	51	12	50	45	95	24

*Model used for SFY 23 / SFY 24 - First half of the six hundred (600) individuals housed (300) is split among the BH I/DD Tailored Plans and PIHP with the second three hundred (300) individuals based on the percentage of the population served by the BH I/DD Tailored Plan and PIHP. The Department is planning for six hundred (600) net transitions each year for the next two (2) years.

Section VI. Attachment X: Annual Housing Expectations*								
LME/MCO	Pop Served	SFY 21 / SFY 22 (2nd half of year) Jan 22 - June 22	SFY 22 / SFY 23	SFY 22 / SFY 23 Quarterly Expectations	SFY 23 / SFY 24 (1st half divided equally)	SFY 23 / SFY24 (2nd half based on pop served)	SFY 23 / SFY 24 Net Year End Total	SFY 23 / SFY 24 Quarterly Expectations
Vaya	18%	29	57	14	50	54	104	26

*Model used for SFY 23 / SFY 24 - First half of the six hundred (600) individuals housed (300) is split among the BH I/DD Tailored Plans and PIHP with the second three hundred (300) individuals based on the percentage of the population served by the BH I/DD Tailored Plan and PIHP. The Department is planning for six hundred (600) net transitions each year for the next two (2) years.